BREEN

v

WILLIAMS

HIGH COURT OF AUSTRALIA

21 November 1995, 6 September 1996

(1996) 186 CLR 71; (1996) 43 ALD 481; (1996) 138 ALR 259; (1996) 70 ALJR 772; [1996] 13 Leg Rep 11; [1996] HCA 57;

Brennan CJ, Dawson, Toohey, Gaudron, McHugh and Gummow JJ

Brennan CJ.

The circumstances which give rise to the issues in this appeal are set out in other judgments. The appellant, who has been a patient of the respondent medical practitioner, claims a legal right to reasonable access to the records kept by the respondent with respect to the appellant and a right to inspect and/or copy those records. Subject to certain admitted exceptions, the appellant submits that that right is enforceable by declaration and injunction. The right is submitted to be based variously on contract, property and fiduciary duty. In my view, none of these bases gives any support to the appellant's claim. I state my reasons.

Contract

In the present case, there was no formal contract between the appellant and the respondent. No more appears than that the appellant consulted the respondent as a medical practitioner and he provided medical services accordingly.

43 ALD 481 at 483

In the absence of special contract between a doctor and a patient, the doctor undertakes by the contract between them to advise and treat the patient with reasonable skill and care. The consideration for the undertaking may be either a payment, or promise of payment, of reward or submission by the patient, or an undertaking by the patient to submit, to the treatment proposed. A duty, similar to the duty binding on the doctor by contract, is imposed on the doctor by the law of torts. The advice and treatment required to fulfil either duty depends on the history and condition of the patient, the facilities available and all the other circumstances of the case.

The provision of advice and treatment with reasonable skill and care may not exhaust the duty of the doctor. Unless the contract between doctor and patient is especially restricted, the doctor's obligation is to maintain or improve the health of the patient generally and to use reasonable skill and care in doing so, even though the advice or treatment required on a particular occasion is in a specialist field or is to be provided only on that occasion or for a limited time. The patient may be thought of as made of many parts some one of which may need treatment at a given time, but the patient is nonetheless an entirety whose life spans, or hopefully spans, the ills or disease of each moment. Once it is perceived that the duty of the doctor is owed to the patient as an entirety, it is not appropriate to assume that the duty is discharged merely by the giving of advice or treatment on the particular occasion.

In some situations, there may be a duty to provide to the patient, or to the patient's nominee, information which the doctor has acquired in the course or for the purpose of advising or treating the patient. That is information received or otherwise acquired by the doctor pursuant to an authority given — expressly or impliedly — by the patient for the purpose of enabling the doctor to perform the doctor's contractual duty to maintain or improve the health of the patient generally. Absent the patient's permission, the doctor must not use that information for any other purpose. When the future medical treatment or physical or mental wellbeing of a patient might be prejudiced by an absence of information about the history or condition or treatment of the patient on an earlier occasion, the doctor who has acquired that information for the benefit of the patient's health must make it available to avoid or diminish that prejudice. Such an obligation is implied by the doctor's acceptance of the patient's authority under the contract to obtain that information. The authority is given in order to benefit the patient's health generally; the authority must be accepted and acted upon for the same purpose. As the obligation is implied, it can be excluded by express provision.

The obligation is not unqualified. As it arises from and is conditioned by the doctor's duty to benefit the patient's health generally, the obligation falls to be discharged only when the patient's health would or might be prejudiced by refusing to make the information available. And, as the service of making the information available is not ordinarily covered by the fee paid for advice or treatment, the doctor is entitled to a reasonable reward for the service.1

For these reasons, I would hold that information with respect to a patient's history, condition or treatment obtained by a doctor in the course or for the purpose of giving advice or treatment to the patient must be disclosed by the doctor to the patient or the patient's nominee on request when (1) refusal to make the disclosure requested might prejudice the general health of the patient, (2) the request for disclosure is reasonable

having regard to all the circumstances, and (3) reasonable reward for the service of disclosure is tendered or assured. A similar duty may be imposed on the doctor by the law of torts but, in particular situations, for example, some emergency treatments, the relationship between doctor and patient may not give rise to a duty that extends so far. It is not necessary now to consider that problem.

An undertaking to provide information is one thing; a duty to give the patient access to, and to permit the patient to copy, the doctor's records is another. The doctor's duty to provide information not only can be discharged, but in some circumstances ought to be discharged, without allowing the patient to see the doctor's records. Where that duty can be performed without giving the patient access to the doctor's records, there is no foundation for implying any obligation to give that access. There is no evidence in this case to suggest that access to the respondent's records might have been necessary to avoid or diminish the possibility of prejudice to the appellant's health.

The appellant argued for an implied term in the contract between the appellant and respondent that the respondent would act in the appellant's “best interests”, even to the extent of testifying for her in litigation. The propounded “best interests” obligation was said to encompass an obligation to give a patient access to the doctor's records. The term implied in the ordinary contract does not go so far. It is limited by the subject matter to which the contract relates, namely, benefiting the health of the patient.

Leaving aside cases where a term is implied in a contract by established mercantile usage or professional practice or by a past course of dealing between the parties,2 a term is not implied in a contract if the contract is effective without it.3 In the present case, it is not suggested that

access to the respondent's records is needed for any therapeutic reason. Nor could such a suggestion be made. The respondent made an open offer to provide a report in writing relating to the history, physical examination findings, investigation results, diagnosis, proposed management plan, treatment or advice furnished to the appellant. That offer, if accepted and if fulfilled, would have discharged any obligation that might have arisen by implication from the contract between the parties. The offer was not accepted, the appellant contending not for a right to be informed but for a right of access to the doctor's records. As the contract between the appellant and respondent was wholly effective without any term entitling the appellant to access to the respondent's records and requiring the respondent to give that access, there is no foundation for implying such a term. Accordingly, the first basis of the appellant's claim fails.

Property

The appellant concedes that the property in the records as chattels is in the respondent. The concession is rightly made. Documents prepared by a professional person to assist the professional to perform his or her professional duties are not the property of the lay client; they remain the property of the professional.4 In the light of that principle, it is not easy to see what relevance the law of property has to the supposed right of the appellant to access to the respondent's records. If (as it was put during argument) the respondent is said to have no proprietary right that would entitle him to refuse access, the question whether the appellant has a right to be given access still remains. On that approach, the supposed right (if any) must find some basis other than property. But even on that approach, the

argument is flawed. Absent some right to require, or the exercise of some power to compel, production of a document for inspection, its owner is entitled by virtue of the rights of ownership to refuse to produce it. As for copying, where the professional person is the owner of the copyright, he or she has the sole right to copy or to permit the copying of the document.5

If the approach is that a right to access and to copy arises because the information contained in the records is proprietary in nature, the approach mistakes the sense in which information is described as property. The sense in which information is so described is stated by Lord Upjohn in Phipps v Boardman6 in these terms:

In general, information is not property at all. It is normally open to all who have eyes to read and ears to hear. The true test is to determine in what circumstances the information has been acquired. If it has been acquired in such circumstances that it would be a breach of confidence to disclose it to another then courts of equity will restrain the recipient from communicating it to another. In such cases such confidential information is often and for many years has been described as the property of the donor, the books of authority are full of such references; knowledge of secret processes, “know-how”, confidential information as to the prospects of a company or of someone's intention or the expected results of some horse race based on stable or other confidential information. But in the end the real truth is that it is not property in any normal sense but equity will restrain its transmission to another if in breach of some confidential relationship.

As information is not property except in the sense stated by Lord Upjohn, the remedies which equity grants to protect against the disclosure of certain kinds of information do not have their source in notions of property. Deane J pointed this out in Moorgate Tobacco Co Ltd v Philip Morris Ltd (No 2):7

Like most heads of exclusive equitable jurisdiction, its rational basis does not lie in proprietary right. It lies in the notion of an obligation of conscience arising from the circumstances in or through which the information was communicated or obtained.

Equity might restrain the respondent from disclosing without authority any information about the appellant and her medical condition that is contained in the respondent's records and, in that sense, it might be arguable that that information is the property of the appellant. Even if such a description were correct — and it is not necessary to consider that question — the description would provide no foundation for the existence of a right to access and to copy enforceable in equity. The mere possession by the respondent of his records relating to the appellant breaches no obligation of conscience and thus it attracts no equitable remedy that might clothe the information with some relevant proprietary character. There is no obligation in conscience requiring the respondent to open his records to inspection and copying by the appellant. Whichever approach is taken to the relevance of the law of property, it fails to provide any basis for the appellant's claim.

Fiduciary duty

Fiduciary duties arise from either of two sources, which may be distinguished one from the other but which frequently overlap.8 One source is agency;9 the other is a relationship

43 ALD 481 at 486

of ascendancy or influence by one party over another, or dependence or trust on the part of that other.10 Whichever be the source of the duty, it is necessary to identify "the subject matter over which the fiduciary obligations extend".11 It is erroneous to regard the duty owed by a fiduciary to his beneficiary as attaching to every aspect of the fiduciary's conduct, however irrelevant that conduct may be to the agency or relationship that is the source of fiduciary duty. As Fletcher Moulton LJ pointed out in Re Coomber; Coomber v Coomber,12 fiduciary relations are of many different types13 and where there is a fiduciary relation the court may interfere and set aside acts which, between persons in a wholly independent position, would have been perfectly valid. His Lordship then added:

Thereupon in some minds there arises the idea that if there is any fiduciary relation whatever any of these types of interference is warranted by it. They conclude that every kind of fiduciary relation justifies every kind of interference. Of course that is absurd. The nature of the fiduciary relation must be such that it justifies the interference. There is no class of case in which one ought more carefully to bear in mind the facts of the case, when one reads the judgment of the court on those facts, than cases which relate to fiduciary and confidential relations and the action of the court with regard to them.

As Mason J said in Hospital Products Ltd v United States Surgical Corp:14

it is now acknowledged generally that the scope of the fiduciary duty must be moulded according to the nature of the relationship and the facts of the case.

In the same case, Gibbs CJ said:15

Fiduciary relations are of different types, carrying different obligations … and a test which might seem appropriate to determine whether a fiduciary relationship existed for one purpose might be quite inappropriate for another purpose.

What is the nature of the doctor-patient relationship? Generally there is no relationship of agency. But the relationship of doctor and patient is one where the doctor acquires an ascendancy over the patient and the patient is in a position of reposing trust in the doctor. Such a relationship casts upon the doctor the onus of proving that any gift received from the

patient was given free from the influence which the relationship produces.16 But in this case the doctor has received no gift; he has taken no step to procure an advantage for himself. Nor has he taken any advantage of his ascendancy over his patient or of her trust in him. His refusal to give access to his records does not deny his patient a benefit to which the patient was entitled either by reason of his position as the appellant's medical adviser and provider of medical treatment or by reason of the trust she reposed in him to provide medical treatment. In Canada, the Supreme Court has held that the relationship between doctor and patient casts on the doctor a fiduciary duty to provide the patient with access to his or her medical records: McInerney v MacDonald.17 But in this respect the notion of fiduciary duty in Canada does not accord with the notion in the United Kingdom.18 Nor, in my opinion, does the Canadian notion accord with the law of fiduciary duty as understood in this country. There is simply no fiduciary relationship which gives rise to a

duty to give access to or to permit the copying of the respondent's records. There is no relevant subject matter over which the respondent's fiduciary duty extended.

Accordingly, the third basis advanced to support the appellant's claim fails. I would add my agreement with what Dawson and Toohey JJ have written as to a patient's “right to know”. As their Honours point out, the appellant did not rely in this court on any such right as a basis of her claim to a right of access to, and to copy, the respondent's records.

The appeal should be dismissed.

Dawson and Toohey JJ.

In 1977 the appellant had a bilateral augmentation mammoplasty which involved the insertion of a silicone implant in each of her breasts. Thereafter she developed bilateral breast capsules. In 1978 she consulted the respondent, who is a plastic surgeon, but not the plastic surgeon who performed the implant. The respondent advised the appellant that the capsules should be compressed and he performed that operation. The appellant experienced severe pain and, after two further consultations with her, the respondent operated and performed a bilateral capsulotomy. The appellant has not consulted the respondent since that operation, although she corresponded with him in 1983 over matters unrelated to this appeal.

In 1984 another doctor, Dr McDougall, diagnosed a lump in the appellant's left breast as silicone gel which had leaked from the breast implant. As a result, he performed a partial mastectomy upon the appellant. Since then she has had further corrective surgery on her left breast and has had the right silicone breast implant replaced. These operations were not performed by the respondent.

The appellant became interested in litigation in the United States by way of a class action against the manufacturer of the breast implants claiming that they were defective. In that litigation she was given the opportunity to “opt in” to a settlement which had been given conditional approval by a United States court. It appears that it was a condition of opting in that the appellant do so before 1 December 1994 and that she file with the United States court copies of medical records in support of any claim which she wished to make. The appellant sought to have access to the medical records kept by the respondent in her case and maintains that she did so both to secure advice whether she should opt in to the United States settlement and to comply with the condition imposed should she decide to do so. She also maintains that she has a right of access to the medical records to ensure that she has all information relating to her health at her disposal which will, in turn, ensure that she is able to make decisions regarding her future treatment.

The appellant could have secured access to the medical records by compulsory court process. It would appear that an order for discovery of the records was within the equitable jurisdiction of the Supreme Court of New South Wales. Another procedure was by way of letters rogatory. These were obtained from the United States court by several litigants in her position and orders were made by the Supreme Court of New South Wales compelling the production of medical records to the court in aid of the United States proceedings. The appellant did not avail herself of this procedure because, she said, the time available was too short. Instead, she commenced this action in the Supreme Court of New South Wales claiming a declaration that she is entitled to access to the medical records kept by the respondent in relation to herself. It is convenient to refer to those as the appellant's medical records, although to some extent this begs the question to be decided in this appeal. The appellant also sought an order that the respondent allow her access to her medical records to examine them and obtain copies of the information contained in them.

Those records were not in evidence but the trial judge, Bryson J, found by inference that they comprised the following:

(a)

The defendant has handwritten notes of his own.

43 ALD 481 at 488

(b)

There may be letters reporting to referral doctors although the evidence does not clearly show this.

(c)

There may be hospital advice slips but the evidence does not clearly show this.

(d)

There is correspondence with the patient, and the defendant does not resist inspection of these and annexed copies to his affidavit.

(e)

There is no evidence whether there are reports to the defendant from other doctors. Dr McDougall wrote him a letter (probably in 1991) about the plaintiff.

(f)

There probably are communications with the NSW Medical Defence Union.

(g)

There probably are photographs.

The trial judge specifically found that there was no document in the appellant's medical records confirming the nature of the implants such as the manufacturer's lot number, a sticker from an implant box or other document of that type. The records, so the trial judge found, did not contain any results of blood or other tests, pathology reports, x-rays or mammograms. These documents were referred to in the appellant's claim for relief. For practical purposes, the relief sought by the appellant related in the end to the respondent's handwritten notes and it was upon these that argument centred.

Of these the respondent said:

The handwritten notes … are prepared and maintained by me, along with the other documents described above in the belief that such records belong to me and are private to me … [S]ome of these records will contain information supplied to me in confidence by family and friends of the patient in circumstances where I have been told by such persons that they do no[t] wish the patient to be aware of their communications with me. Often the information I receive from such sources is what I would regard as sensitive and confidential, and I would not wish to divulge my knowledge of it or source unless I judged it necessary to do so in the interest of the patient. In some cases because of the state of mind or health of the patient these records will contain information the disclosure of which in my judgment might be detrimental to the patient's well being if disclosed at all or if disclosed without full explanation. Because these notes are prepared by me in the belief that they will remain private to me, they often contain conclusions, commentary and musing which might well be different in form and substance if the notes were prepared by me in the knowledge that the patient was entitled to a copy of my records. I would be concerned that these notes and some of the other records maintained by me might, at least in some cases, cause confusion and unnecessary worry and stress to patients if they were made available to them without adequate explanation. Finally, in part, these notes contain information which relates solely to the business and administration of my practice and not to aspects of the treatment and management of my patients.

On 4 August 1993 the appellant's solicitors wrote to the respondent requesting copies of the appellant's medical records, not a medical report. By a letter dated 10 August 1993 the respondent replied to the appellant herself, saying:

As [your solicitors] well know, it is a longstanding legal tradition in this country that such records are the doctor's property, an aide memoire to his treatment of the patient, and may only be released on production of a court subpoena.

Accordingly the advice which I have received from my medical defence legal advis[e]rs is that this situation still holds, but that they would be very happy for me to release your records, were you to supply me with a document which would release me from any claim that might arise in relation to my treatment of you.

Despite the reference in that letter to a claim against the respondent, the appellant has not sought, nor does she seek, to make any claim against the respondent based upon his default. Had she commenced proceedings upon that basis she would have been entitled to discovery of her medical records in the ordinary course. Nevertheless, the appellant was not prepared to give the undertaking sought by the respondent's insurers and sought access to her medical records as of right.

43 ALD 481 at 489

During the trial of the appellant's action, the respondent made an open offer to provide a report in writing to the appellant about the contents of her medical records, excluding his correspondence with the New South Wales Medical Defence Union and with the appellant's solicitors. The offer encompassed the history taken by the respondent, his physical examination findings, investigation results, diagnosis and proposed management plan, treatment or advice. The offer was not accepted but was not withdrawn. The trial judge found that the appellant did not wish to have a report such as that offered by the respondent and thus regarded himself as not called upon to consider whether the respondent's readiness to provide a report was reasonable or extended sufficiently far to satisfy any contractual duty which the respondent might have to provide a report.

Notwithstanding the purposes which the appellant asserted for wanting access to her medical records, her claim was that, in general, any patient is entitled to require from a treating doctor copies of all records relating to that patient for whatever purpose the patient has in mind. The trial judge concluded that:

It was the wish of the plaintiff and those representing her to treat the litigation as an opportunity to test whether a patient has a right of access to all information in medical records maintained by the patient's treating doctor, and to test the contrary proposition that it is within the power of the treating doctor to grant or withhold access to those records as the doctor decides.

However, the appellant conceded that the right which she asserted must be subject to qualification. She accepted that "a doctor may withhold information where disclosure would be adverse to the patient's interests" and referred to this as the "therapeutic privilege".19

The trial judge refused the appellant the relief which she sought. She appealed to the New South Wales Court of Appeal which, by a majority (Mahoney and Meagher JJA; Kirby P dissenting), dismissed the appeal.20 It is from the order of the Court of Appeal that the appellant now appeals to this court.

In at least one respect the appellant's case was presented in an unsatisfactory form. Although her claim related to specific medical records, she made no attempt to obtain access to those records in the course of the proceedings which she commenced or in any other proceedings. She did not seek discovery of them nor did she seek to subpoena them. The result was that the trial judge was asked to make a declaration (or an order) in respect of documents which he had not seen and the nature of which he could only determine by inference. Not only that, but it could not be said whether the documents fell within any exception to any right on the part of the appellant to have access to them, at least one exception, the so-called therapeutic privilege, having been acknowledged as part of the appellant's case.21 No doubt the power to grant declaratory relief is wide,22 but even in a test case a claimant must establish a cause of action upon the particular facts of the case. Thus it has been said that a person seeking declaratory relief must have a real interest and relief will not be granted if the question is purely hypothetical, if relief is claimed in relation to circumstances that have not occurred and might never occur or if the court's declaration will produce no foreseeable consequences for the parties.23 It is relevant in that context to observe that there was no exploration in argument whether, had the appellant

obtained access to the medical records in the course of litigation, that would have had any effect upon her entitlement to the relief which she claims.

That observation having been made, it is convenient to turn to the way in which the appellant put her case. She contended that a right of access to her medical records arose from three sources, namely, a patient's proprietary right or interest in the information contained in the records, an implied term of the contract between patient and doctor and a fiduciary relationship between patient and doctor. In addition, it is fair to say that the appellant's submissions were pervaded by a more general assertion of what was said to be a patient's "right to know". That right was not said to arise from any particular source, but was said to reflect the law's acceptance of personal inviolability and patient autonomy and its rejection of a paternalistic approach involving the application of standards determined exclusively by the medical profession. In this latter respect, the appellant relied upon the recent decision of this court in Rogers v Whitaker.24 We now turn to deal with each of these contentions.

Proprietary right or interest

The appellant did not claim ownership of the actual documents comprising her medical records. It is understandable that she did not do so, because they do not include any documents obtained on her behalf and paid for by her, such as x-ray photographs or pathology reports, the ownership of which she may well be able to claim. As we have said, for all practical purposes they comprise the written notes of the respondent and with respect to these there can be no doubt that they are the property of the respondent. The duty of the respondent, both in contract and tort, was to exercise reasonable care and skill in giving treatment and advice25 and it was in carrying out this duty that the respondent compiled the records. In doing so the respondent did not act as agent for the appellant and the documents were his property alone. The general principle is that documents brought into existence by an agent while in the employ of a principal belong to the principal and not to the agent.26 Of course, sometimes in a relationship between a professional and a client, the professional may act as an agent in the course of providing services in which case documents brought into existence may be the property of the client. For example, a contract or deed produced by a solicitor for a client and paid for by the client is the property of the client. On the other hand, as was observed in Chantrey Martin v Martin:27

Even in the case of a solicitor there must, we should have thought, be instances of memoranda, notes, etc, made by him for his own information in the course of his business which remain his property, although brought into existence in connection with work done for clients.

In this case, the appellant's medical records were clearly compiled by the respondent for his own information in treating and advising the appellant and not in any sense as agent for the appellant. The appellant was correct, in our view, in not seeking to contest the ownership by the respondent of the records.

On the other hand, the appellant encounters no less difficulty in seeking to maintain that she has, in the information recorded by the records, a proprietary right or interest which

43 ALD 481 at 491

entitles her to access to them. No analogy can be drawn between her situation and that of a beneficiary under a trust. Of that relationship Lord Wrenbury said in O'Rourke v Darbishire:28

If the plaintiff is right in saying that he is a beneficiary, and if the documents are documents belonging to the executors as executors, he has a right to access to the documents which he desires to inspect upon what has been called in the judgments in this case a proprietary right. The beneficiary is entitled to see all trust documents because they are trust documents and because he is a beneficiary. They are in this sense his own. Action or no action, he is entitled to access to them.

Those remarks were accepted or referred to without demur in Re Londonderry's Settlement29 and have been accepted in this country.30 But the right of access of a beneficiary to trust documents arises because of the beneficial interest of the beneficiary in the trust property and it is in that sense that the right may be described as proprietary. The relationship between doctor and patient is not that of trustee and beneficiary, although for certain purposes, as will be seen, duties of a fiduciary nature may be imposed upon the doctor. Essentially the relationship between doctor and patient is a contractual one whereby the doctor undertakes to treat and advise the patient and to use reasonable skill and care in so doing. That affords no basis for a proprietary interest in records kept by the doctor for the purpose of carrying out that function.

The appellant's contention is, however, that the information contained in the records can be separated from the records themselves and it is in the information that the appellant has a proprietary right or interest entitling her to access to the records. But there can be no proprietorship in information as information, because once imparted by one person to another, it belongs equally to them both.31 It is true, as Gummow J recognised in Smith Kline & French Laboratories (Aust) Ltd v Secretary, Department of Community Services and Health,32 that equity acts to protect confidential information and the degree of protection afforded makes it appropriate to describe it as having a proprietary character, but that is not because property is the basis upon which protection is given. It is because of the effect of that protection. In this case, while the information provided by the appellant to the respondent was no doubt confidential, there is no question of any abuse by the respondent of that confidence and there is no property in that information in any sense upon which the appellant might base the right which she asserts.

During argument, the question of the doctor's copyright in her medical records was raised with the appellant upon the basis that the right of access claimed by her extended to the making of copies of those records. The appellant made no submissions upon this question and it is unnecessary to reach any conclusion, but obviously it would raise problems if the appellant were otherwise to succeed in her contentions.

Implied term

The implication of a term in a contract is based upon the presumed or imputed intention of the parties. In the case of a formal contract which is complete on its face, it may be said in general that no implication arises (save where it is a legal incident of a particular class

of contract) unless it is necessary or obvious — necessary in the sense of being required to give business efficacy to the contract or obvious in the sense that it goes without saying.33 Where, however, as in this case, there is no formal agreement, the actual terms of the contract must be inferred before any question of implication can arise. The test which is then to be applied was formulated by Deane J in Hawkins v Clayton in these terms:34

The most that can be said consistently with the need for some degree of flexibility is that, in a case where it is apparent that the parties have not attempted to spell out the full terms of their contract, a court should imply a term by reference to the imputed intention of the parties if, but only if, it can be seen that the implication of the particular term is necessary for the reasonable or effective operation of a contract of that nature in the circumstances of the case. That general statement of principle is subject to the qualification that a term may be implied in a contract by established mercantile usage or professional practice or by a past course of dealing between the parties.

That is to say, no question of there being an obvious implication arises in such a case because that which is obvious will be a term of the contract as a matter of inference. Moreover, the line between inference and implication will not always be easy to draw.

However, it is common ground that the obligation of the respondent under the contract between him and the appellant was to use reasonable skill and care in treating and advising the appellant. It is unnecessary to pause to examine whether that standard of care was imposed upon the respondent by inference, by implication or as a legal incident of that kind of contract. Nor is it necessary to consider the effect of the overlap of the duty imposed in contract and in tort in this area.35 What can be said is that it was not necessary for the reasonable or effective performance of that obligation that the respondent should be obliged to give the appellant access to her medical records. The careful and skilful treatment of the

appellant may have required the respondent to provide her or others with such information as was necessary to ensure proper ongoing care for her health, but the respondent was prepared to provide that information, albeit in the form of a report and not by direct access to the records. Indeed, as the respondent pointed out, for him to have given the appellant free access to all the matters contained in her medical records may not have been in her interests and may have fallen short of the standard of skill and care required of him. This led the appellant to concede an exception to the obligation for which she contended in the form of the so-called therapeutic privilege, but the need for the concession, rather than supporting the existence of such an obligation, tends to show that the obligation was neither a necessary nor reasonable incident of the contract between the parties in the first place. There can be no suggestion that it was an established professional practice for a medical practitioner to afford a patient access to the patient's medical records — the evidence was entirely to the contrary — and in our view there is no foundation for the implied term upon which the appellant relies.

Fiduciary duty

While duties of a fiduciary nature may be imposed upon a doctor, they are confined and do not cover the entire doctor-patient relationship. Thus a doctor is under a duty to protect

the confidentiality of information given by a patient.36 And the doctor-patient relationship is such that any substantial benefit received by the doctor from a patient (other than proper remuneration) is presumed to be the result of undue influence with the doctor bearing the onus of rebutting the presumption.37 Whether these aspects of the doctor-patient relationship are properly to be described as fiduciary may be a matter of debate. For example, in Moorgate Tobacco Co Ltd v Philip Morris Ltd (No 2)38 Deane J saw the protection afforded by equity to confidential information as something separate from a wider fiduciary duty arising from the general nature of a relationship. Similarly, academic writers have classified the doctrine of undue influence as standing apart from a more general fiduciary doctrine.39 But the debate is not worth pursuing in the present context because it is plain that the appellant relies upon a wider fiduciary relationship between her and the respondent as giving rise to a duty on the part of the respondent to afford her access to her medical records.

The difficulty in dealing with the appellant's contention is that the law has not, as yet, been able to formulate any precise or comprehensive definition of the circumstances in which a person is constituted a fiduciary in his or her relations with another. There are accepted fiduciary relationships, such as trustee and beneficiary, agent and principal, solicitor and client, employee and employer, director and company, and partners, which may be characterised as relations of trust and confidence. In Hospital Products Ltd v United States Surgical Corp Mason J said:40

The critical feature of these relationships is that the fiduciary undertakes or agrees to act for or on behalf of or in the interests of another person in the exercise of a power or discretion which will affect the interests of that other person in a legal or practical sense. The relationship between the parties is therefore one which gives the fiduciary a special opportunity to exercise the power or discretion to the detriment of that other person who is accordingly vulnerable to abuse by the fiduciary of his position. The expressions “for”, “on behalf of”, and “in the interests of” signify that the fiduciary acts in a “representative” character in the exercise of his responsibility.

Mason J did not intend to suggest that this description of a fiduciary relationship isolated those features from other relationships of trust and confidence which do not impose fiduciary obligations. It is not the case that whenever there is “a job to be performed”,41 and entrusting

the job to someone involves reposing substantial trust and confidence in that person, a fiduciary relationship arises. But it is of significance that a fiduciary acts in a representative character in the exercise of his responsibility.

A doctor is bound to exercise reasonable skill and care in treating and advising a patient, but in doing so is acting, not as a representative of the patient, but simply in the exercise of his or her professional responsibilities. No doubt the patient places trust and confidence in the doctor, but it is not because the doctor acts on behalf of the patient; it is because the patient is entitled to expect the observance of professional standards by the doctor in matters of treatment and advice and is afforded remedies in contract and tort if those standards are not observed and the patient suffers damage.

Equity requires that a person under a fiduciary obligation should not put himself or herself in a position where interest and duty conflict or, if conflict is unavoidable, should

resolve it in favour of duty and, except by special arrangement, should not make a profit out of the position.42 The application of that requirement is quite inappropriate in the treatment of a patient by a doctor or in the giving of associated advice. There the duty of the doctor is established both in contract and in tort and it is appropriately described in terms of the observance of a standard of care and skill rather than, inappropriately, in terms of the avoidance of a conflict of interest. It has been observed that what the law exacts in a fiduciary relationship is loyalty, often of an uncompromising kind, but no more than that.43 The concern of the law in a fiduciary relationship is not negligence or breach of contract. Yet it is the law of negligence and contract which governs the duty of a doctor towards a patient. This leaves no need, or even room, for the imposition of fiduciary obligations. Of course, fiduciary duties may be superimposed upon contractual obligations and it is conceivable that a doctor may place himself in a position with potential for a conflict of interest — if, for example, the doctor has a financial interest in a hospital or a pathology laboratory — so as to give rise to fiduciary obligations.44 But that is not this case.

Thus in Rogers v Whitaker,45 where the issue was the extent of a doctor's obligation to inform a patient of the risks inherent in proposed treatment, the court based its decision squarely upon the duty of the doctor to observe the appropriate standard of care and not upon any fiduciary relationship. The majority said:46

The law imposes on a medical practitioner a duty to exercise reasonable care and skill in the provision of professional advice and treatment. That duty is a “single comprehensive duty covering all the ways in which a doctor is called upon to exercise his skill and judgment”;47 it extends to the examination, diagnosis and treatment of the patient and the provision of information in an appropriate case.48 It is of course necessary to give content to the duty in the given case.

The appellant relied upon the decision of the Canadian Supreme Court in McInerney v MacDonald49 in which La Forest J, delivering the judgment of the court, held that a patient is entitled to reasonable access to examine and copy the doctor's records. Non-disclosure, his Lordship held, may be warranted only if there is real potential for harm either to the patient or to a third party and there is a general superintending jurisdiction in the court. La Forest J accepted that the medical records in that case were the property of the doctor and declined to rest the obligation which he found to exist upon an implied contractual term. It was conceded by the appellant physician that a patient has a right to be advised about the information concerning his or her health in the physician's medical records, but La Forest J, relying upon a line of United States cases,50 concluded that “the fiducial qualities of the relationship

extend the physician's duty beyond this to include the obligation to grant access to the information the doctor uses in administering treatment".51 In basing the duty upon a fiduciary relationship, La Forest J was giving expression to the view that it is the duty of the doctor to act with "utmost good faith and

43 ALD 481 at 495

loyalty".52 Such a duty hardly fits with the undoubted duty of a doctor in this country to exercise reasonable skill and care in the giving of treatment and advice. It is, perhaps, reflective of a tendency, not found in this country, but to be seen in the United States and to a lesser extent Canada, to view a fiduciary relationship as imposing obligations which go beyond the exaction of loyalty and as displacing the role hitherto played by the law of contract and tort by becoming an independent source of positive obligations and creating new forms of civil wrong.53 But, with respect, that is achieved by assertion rather than analysis and, while it may effectuate a preference for a particular result, it does not involve the development or elucidation of any accepted doctrine. There is no foundation in either principle or authority in this country, however different the position may be in Canada, for the conclusion reached by La Forest J that:54

information about oneself revealed to a doctor acting in a professional capacity remains, in a fundamental sense, one's own. The doctor's position is one of trust and confidence. The information conveyed is held in a fashion somewhat akin to a trust. While the doctor is the owner of the actual record, the information is to be used by the physician for the benefit of the patient. The confiding of the information to the physician for medical purposes gives rise to an expectation that the patient's interest in and control of the information will continue.

It should be observed in relation to that passage that the court was not concerned in that case, as we are not in this, with a patient's right to information. It was concerned with access to the actual records containing the information, notwithstanding that in places the passage appears to regard "information" as interchangeable with "the actual record".

In England, s 3 of the Access to Health Records Act 1990 (UK) gives a prima facie right of access to health records by the individuals to whom they relate and other persons, but s 5(1) provides:

Access shall not be given under section 3(2) above to any part of a health record:

(a)

which, in the opinion of the holder of the record, would disclose:

(i)

information likely to cause serious harm to the physical or mental health of the patient or of any other individual; or

(ii)

information relating to or provided by an individual, other than the patient, who could be identified from that information; or

(b)

which was made before the commencement of this Act.

That Act was passed as a result of the decision of the European Court of Human Rights in Gaskin v United Kingdom55 which held that the refusal to allow access by the applicant to certain health records was in breach of his right to respect for his private and family life

under Art 8 of the European Convention for the Protection of Human Rights and Fundamental Freedoms 1950.

In R v Mid Glamorgan Family Health Services Authority the Court of Appeal56 upheld a decision by Popplewell J57 dismissing an application by a patient for access to his medical records. Popplewell J was of the view that there had been no breach of Art 8 because the respondent had offered to make available the records (which predated the 1990 Act) to an independent medical adviser who might judge whether the information was likely to cause harm to the applicant or anyone else. However, he reached "the

43 ALD 481 at 496

clearest possible conclusion"58 that at common law there was no right of access by the applicant to records pre-existing the Access to Health Records Act. In the Court of Appeal Nourse LJ (with whom the other members of the court agreed) referred in his judgment to the well-known passage in the speech of Lord Templeman in Sidaway v Governors of Bethlem Royal Hospital in which he said:59

I do not subscribe to the theory that the patient is entitled to know everything nor to the theory that the doctor is entitled to decide everything. The relationship between doctor and patient is contractual in origin, the doctor performing services in consideration for fees payable by the patient. The doctor, obedient to the high standards set by the medical profession, impliedly contracts to act at all times in the best interests of the patient. No doctor in his senses would impliedly contract at the same time to give to the patient all the information available to the doctor as a result of the doctor's training and experience and as a result of the doctor's diagnosis of the patient. An obligation to give a patient all the information available to the doctor would often be inconsistent with the doctor's contractual obligation to have regard to the patient's best interests. Some information might confuse, other information might alarm a particular patient. Whenever the occasion arises for the doctor to tell the patient the results of the doctor's diagnosis, the possible methods of treatment and the advantages and disadvantages of the recommended treatment, the doctor must decide in the light of his training and experience and in the light of his knowledge of the patient what should be said and how it should be said.

Nourse LJ observed that that passage provided "a sensible basis for holding that a doctor, likewise a health authority, as the owner of a patient's medical records, may deny the patient access to them if it is in his best interests to do so".60 However, Lord Templeman was referring to information and was not directing his attention to a patient's right of access to the physical records. Moreover, his remarks were made in the context of the duty of a doctor to warn of risks inherent in treatment which a patient has a right to refuse or accept. It is difficult, therefore, to gauge the intended effect of the concluding observation of Nourse LJ where he said:61

It is inherent in the views above expressed that I do not accept that a health authority, any more than a private doctor, has an absolute right to deal with medical records in any way that it chooses. As Lord Templeman makes clear, the doctor's general duty, likewise the health authority's, is to act at all times in the best interests of the patient.

It is indeed the doctor's duty to act in the best interests of the patient — if by that is meant no more than that the doctor must exercise reasonable care and skill in the treatment and advice of the patient — and that may require that a doctor provide information from his records regarding a particular patient. But that is not to say that the patient has a right to those records. Indeed, reposing judgment in the doctor of what is in the best interests of the patient is to deny that proposition because if a doctor is to judge what information is to be provided

in the interests of the patient and, having made that judgment, must provide the information, no point is to be served by a right of access to the records, qualified or unqualified, on the part of the patient. We are not, of course, speaking of litigation where a patient has a right of access to the records for the purposes of the litigation. Nourse LJ identified no legal source for a right of access otherwise. Certainly

he did not suggest the existence of any fiduciary duty giving rise to it. There would have been difficulty in his doing so for in Sidaway Lord Scarman (in dissent, but not on this point) said:62

Counsel for the appellant referred to Nocton v Lord Ashburton63 in an attempt to persuade your Lordships that the relationship between doctor and patient is of a fiduciary character entitling a patient to equitable relief in the event of a breach of fiduciary duty by the doctor. The attempt fails: there is no comparison to be made between the relationship of doctor and patient with that of solicitor and client, trustee and cestui qui trust or the other relationships treated in equity as of a fiduciary character.

We can find no basis in the law of this country for discerning a fiduciary relationship between doctor and patient carrying with it a right of access on the part of a patient to medical records compiled by the doctor in relation to that patient.

The “right to know”

The appellant did not submit before this court that she had a right to know the contents of her medical records independently of her claims arising from proprietorship of the information contained in the records, from contract and from the existence of a fiduciary relationship between herself and the respondent. However, she sought to call in aid in furtherance of those claims something which she called a movement in the law governing the relationship of doctor and patient in the direction of acceptance of the principle of personal inviolability and patient autonomy and the rejection of medical paternalism. In this regard she sought to rely upon the decision in Rogers v Whitaker.64

There are two observations which may be made about that case. The first is that it was concerned with the provision of information, not access to medical records, by a doctor in the context of a decision to be made by a patient whether to undergo proposed treatment. The second observation is that the decision affirmed the proposition to which we have earlier referred, namely, that it is a matter of judgment for the doctor to determine what the patient should know in his or her best interests. It was pointed out that in making that judgment the doctor is required to exercise reasonable skill and care and that the court would determine for itself whether that standard was observed rather than apply the Bolam65 approach which placed reliance upon the opinion of a responsible body of medical practitioners. Nevertheless it was held that it is a judgment to be made by the doctor, notwithstanding that in the particular context of the revelation of the risks inherent in proposed treatment all relevant information to enable the patient to make a decision whether to undergo the treatment would ordinarily be required. In that sense the case does affirm patient autonomy. We are not able to discern that the case has anything additional to say about personal inviolability (whatever that may mean in the context). Nor does it have anything to say about medical paternalism save, perhaps, to the extent that it decides that it is for the court, not medical opinion, to determine whether the required standard of care has been observed.

It will be apparent from what we have already said that we can detect no movement in the law which would sustain the appellant's claims. We have endeavoured to explain why the appellant is not, in our view, the owner of the information contained in her medical records

and why there is no basis for the implication of the term for which she contends in the contract between her and the respondent or for the recognition of any relevant fiduciary relationship. In any event, even if the movement in the law claimed by

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the appellant were to exist it could have no significance where established principle points to a clear conclusion as, in our view, it does in this case.

No doubt considerations of policy (and that is what this part of the appellant's argument involves) may justifiably influence the adaptation or development of the law or the recognition of new categories where that is open upon the basis of settled legal principle. But policy considerations cannot justify abrupt or arbitrary change involving the abandonment of settled principle in favour of a particular result which is merely perceived as desirable.

In any event, the desirability of the result which the appellant advocates is far from self-evident. There is more than one view upon the matter and the choice between those views, if a choice is to be made, is appropriately for the legislature rather than a court. Indeed, the declaration sought by the appellant, which Gummow J reproduces in his judgment, is cast in terms which make plain its legislative character.

For these reasons, we would dismiss the appeal.

Gaudron and McHugh JJ.

The question in this appeal is whether a patient has a right to inspect and/or obtain copies of his or her medical records that are held by that person's doctor.

In the Supreme Court of New South Wales, Bryson J held that the appellant, Ms Julie Breen, a patient of the respondent, Dr Cholmondeley W Williams, did not have a right to copy or to have access to her medical records. A majority of the Court of Appeal of the Supreme Court (Mahoney and Meagher JJA) agreed with the decision of Bryson J.66 Kirby P, dissenting, held that a doctor owes a patient a fiduciary duty which entitles the patient to inspect or obtain copies of his or her medical records.67 Pursuant to the grant of special leave, Ms Breen now appeals to this court against the order of the Court of Appeal. In our opinion, the appeal should be dismissed.

The factual background

In October 1977, Ms Breen underwent a bilateral augmentation mammoplasty operation involving the insertion of silicone implants in her breasts. Sometime after the operation she noticed the development of breast capsules. She consulted Dr Williams who, after a series of consultations, performed a bilateral capsulotomy operation on Ms Breen in November 1978. In 1984, another surgeon removed the implants. Apart from correspondence in 1983 as to the possible removal of the implants and other unrelated medical conditions, Ms Breen and Dr Williams appear to have had no further contact until the correspondence, commencing in 1993, which gave rise to this litigation.

In 1993, Ms Breen became involved in a class action in the United States of America against the company which manufactured the implants. In that action, the plaintiffs claimed that the implants were defective. On 4 August 1993, her lawyers wrote to Dr Williams asking if he would forward to them photocopies of medical records in his possession concerning Ms Breen. Dr Williams replied that he would release the records to Ms Breen if she would supply him “with a document which would release [him] from any claim that might arise in relation to [his] treatment” of her. Ms Breen declined to give this undertaking.

The right of access

A claim that a patient has a right of access to his or her medical records is a question of great social importance. But absent a contractual term, such a claim has no foundation

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in the law of Australia. Nevertheless, every possible argument that could be made in support of the claim by Ms Breen was put. Dr Cashman, who appeared for Ms Breen, contended that one or more of five legal principles or doctrines supported or gave to Ms Breen a right of access to records in the possession of Dr Williams that relate to his treatment of her, subject to lawful exceptions.

First, the common law gave her a "proprietary right and interest" in the actual information contained in Dr Williams' records. Secondly, the common law implied a term in the contract between her and Dr Williams to the effect that she had a right of access to the documents in Dr Williams' file. Thirdly, there was an innominate common law right of access to medical records. Fourthly, the common law recognised a patient's "right to know" all necessary information concerning his or her medical treatment including, where requested, access to records containing that information. Fifthly, the law imposed on Dr Williams a fiduciary duty, enforceable in a court of equity, to give her access to her medical records.

Did Ms Breen have a proprietary right or interest in the medical records?

Dr Cashman did not submit that Ms Breen owned the actual documents which comprised the medical file. She did not, he said, "seek to divest the doctor of the pieces of paper" comprising the records. The concession that Ms Breen did not own the documents was plainly correct. Professional persons are not ordinarily agents of their clients even though they often have express, implied or ostensible authority to enter into contracts on their clients' behalf. Documents prepared by an agent are ordinarily the property of the principal. But documents prepared by a professional person to assist him or her to do work for a client are the property of the professional person, not the lay client. Speaking of documents which a firm of valuers had prepared in the course of its professional employment, MacKinnon LJ said:68

If an agent brings into existence certain documents while in the employment of his principal, they are the principal's documents and the principal can claim that the agent should hand them over, but the present case is emphatically not one of principal and agent. It is a case of the relations between a client and a professional man to whom the client resorts for advice. I think it would be entirely wrong to extend to such a relation what may be the legal result of the quite different relation of principal and agent … [The documents in question] are documents which he has prepared for his own assistance in carrying out his expert work, not documents brought into existence by an agent on behalf of his principal, and, therefore, they cannot be said to be the property of the principal.

The doctor-patient relationship, like that of valuer and client, is not one of agent and principal. Dr Williams' notes were prepared to assist him to fulfil his professional duties. The property in the medical records relating to Ms Breen which he prepared belongs to him; Ms Breen has no proprietary right in respect of those records. The right of ownership of Dr Williams is, statute or contract apart, good against the world and entitles Dr Williams to prevent any person from having access to those records.

Although Dr Cashman conceded that Ms Breen did not own the records, he contended that she had a proprietary right or interest in the documents that entitled her to access to them. The premise of this argument was that the records were not owned by anybody. However, the idea that an item of personal property that has not been abandoned has no owner is ill-founded.

Ownership may be divisible in the sense that one or more of the collection of rights constituting ownership may be detached and vested in a number of

43 ALD 481 at 500

persons. Ownership may also be divorced from possession in numerous circumstances.69 But the notion that personal property that has not been abandoned may have no owner is one that is foreign to the common law. Statute or contract apart, medical records, prepared by a doctor, are the property of the doctor. That property right entitles the doctor to refuse other persons access to the records. Dr Cashman's argument based on Ms Breen having a proprietary right or interest in the records must fail.

Was a right of access an implied contractual term?

The doctor-patient relationship is contractual in origin.70 In general terms, "[a] doctor offers a patient diagnosis, advice and treatment", the objectives of which are "the prolongation of life, the restoration of the patient to full physical and mental health and the alleviation of pain".71 Given the informal nature of the relationship, however, a contract between a doctor and a patient rarely contains many express terms. Because that is so, the courts are obliged to formulate the rights and obligations of the parties to the contract. As Lord Wilberforce has put it, in cases where the parties to a contract have not attempted to spell out all the terms of their contract, the function of the court is "simply … to establish what the contract is, the parties not having themselves fully stated the terms".72 The court does so by implying terms in the contract in accordance with established legal principles.

The common law draws a distinction between terms which are implied in fact and terms which are implied by law. Leaving aside terms that are presumed to apply because of the custom of a trade or business, the courts will only imply a term in fact when it is necessary to give efficacy to the contract.73 A term implied in fact purports to give effect to the presumed intention of the parties to the contract in respect of a matter that they have not mentioned but on which presumably they would have agreed should be part of the contract.74 A term implied by law on the other hand arises from the nature, type or class of contract in question.75 Some terms are implied by statutes in contracts of a particular class, for example, money lending and home building contracts. Such terms give effect to social and economic policies which the legislature thinks are necessary to protect or promote the rights of one party to that class of contract. Other terms are implied by the common law because, although originally based on the intentions of parties to specific contracts of particular descriptions, they "became so much a part of the common understanding as to be imported into all transactions of the particular description".76 Many of these terms are implied to prevent "the enjoyment of the rights conferred by the contract [being] rendered nugatory, worthless, or, perhaps, … seriously undermined", the notion

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of necessity being central to the rationale for such an implication.77 The distinction between terms implied by law and terms implied in fact can tend in practice to "merge imperceptibly into each other".78

The argument for Ms Breen started with the premise that, by implication of law, a doctor always contracts with a patient to act in the patient's "best interests". To support this premise, Dr Cashman relied on the following statement of Lord Templeman in Sidaway v Governors of Bethlem Royal Hospital:79

The doctor, obedient to the high standards set by the medical profession impliedly contracts to act at all times in the best interests of the patient.

From this premise, Dr Cashman argued that, as an incident of the "best interests" term, the doctor must make available medical records concerning a patient when the patient seeks access to them. The leap from the premise to the conclusion is a long one. But we can pass that by.

While the notion of "best interests" is a relevant consideration in some areas of the law, such as the law relating to child welfare,80 a doctor does not impliedly promise that he or she will always act in the "best interests" of the patient. The primary duty that a doctor owes a patient is the duty "to exercise reasonable care and skill in the provision of professional advice and treatment".81 The doctor does not warrant that he or she will act in the patient's best interests or that the treatment will be successful.82 If a doctor owed such a duty, he or she would be liable for any act that objectively was not in the best interests of the patient. The doctor would be liable for treatment that went wrong although he or she had acted without negligence. That is not the law of Australia.

There are good reasons why Australian courts do not imply a "best interests" term, as a matter of law, into all doctor-patient contractual relationships. First, "[w]here a term is implied into a contract it will usually embody a contractual promise and therefore create a legal duty".83 Such a duty would be inconsistent with the existing contractual and tortious duty to exercise reasonable care and skill in the provision of professional advice and treatment. The existence of a tortious duty of care militates against "the implication of … a general contractual duty of care",84 particularly where "the incidents of an independent general contractual duty of care would differ from those of an independent tortious duty".85 Secondly, the meaning and application of an implied term must be reasonably certain.86 The notion of "best interests" has been criticised as uncertain in the context of child welfare.87 That criticism is just as pertinent, if not more so, in the context of contract law which places a premium on certainty.

Even if Australian law implied a term in the contract between doctor and patient that the doctor would act in the patient's best interests in the sense that Lord Templeman

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propounded in Sidaway, it would not assist Ms Breen's claim to a right of access to medical records concerning her. Lord Templeman was not asserting that a doctor owed a general duty to act in the best interests of the patient. He used the term in the context of medical advice and treatment. In the paragraph preceding the statement upon which Dr Cashman relies, Lord Templeman had said that "[a] doctor offers a patient diagnosis, advice and treatment".88 It was in that context that his Lordship went on to say that the doctor "impliedly contracts to act at all times in the best interests of the patient".89 The duty was not one applying in respect of all matters arising out of the doctor-patient relationship and subsisting for an indefinite period. Only within the context of "diagnosis, advice and treatment"90 was the duty to act in the "best interests" of the patient active. Moreover, "[i]t is difficult to see how a duty to act in the patient's `best interests' can differ in any substantive way from a doctor's duty to exercise reasonable care in practising the skills of medicine".91 In addition, Lord Templeman was not formulating an objective test of "best interests". The whole point of his speech in Sidaway was that it was primarily a matter for the doctor to determine what was in the patient's best interests. He said92 that "the doctor, bearing in mind the best interests of the patient and bearing in mind the patient's right of information which will enable the patient to make a balanced judgment must decide what information should be given to the patient and in what terms that information should be couched".

For these reasons, the common law did not imply a term in the contract between Dr Williams and Ms Breen that he would always act in her best interests or that she had a right of access to his record of her treatment. So far as advice and treatment were concerned, the only relevant contractual term implied by law was to exercise reasonable care and skill.

Finally, no ground exists for implying a "best interests" term as a matter of fact. The term was not "so obvious that `it goes without saying' ", nor was it "necessary to give business efficacy to the contract".93

Accordingly, no implied term of the contract between Ms Breen and Dr Williams entitles her to access to the medical records in his possession.

Is there an innominate common law right of access to medical records?

Dr Cashman relied on the decision of the English Court of Appeal (Nourse, Evans LJJ and Sir Roger Parker) in R v Mid Glamorgan Family Health Services94 to assert that there is an "innominate" common law right of access to medical records. The Court of Appeal held in that case that a public health authority had a "duty to administer its property in accordance with its public purposes"95 and that, as the owner of a patient's medical records, the authority may deny a patient access to his or her records if it is in the best interests of the patient to do so.96 The Court of Appeal upheld the primary judge's conclusion that an offer to make the records of the plaintiff available to his medical advisers satisfied this duty.

43 ALD 481 at 503

Contrary to the view that we have expressed, Nourse LJ thought that Lord Templeman's speech in Sidaway97 had decided that a doctor had a duty to act at all times in the best interests of the patient and that it was a "general duty".98 Nourse LJ went on to say that "[t]hose interests would usually require that a patient's medical records … should usually, for example, be handed on by one doctor to the next or made available to the patient's legal advisers if they are reasonably required for the purposes of legal proceedings in which he is involved".99 But, as we have said, we do not think that Lord Templeman intended to lay down so sweeping a duty. In any event, for the reasons that we have given, in Australia no such duty is implied in the contractual relationship between a doctor and patient.

It follows that Mid Glamorgan Family Health Services is not an authority that has any persuasive effect in this country.

Does a doctor owe a fiduciary duty to a patient to give the patient access to that person's medical records?

Dr Cashman contends that the doctor-patient relationship is fiduciary in nature and that a doctor who denies a patient reasonable access to medical files concerning that patient is in breach of this fiduciary duty. In our opinion, this submission must be rejected.

Australian courts have consciously refrained from attempting to provide a general test for determining when persons or classes of persons stand in a fiduciary relationship with one another. This is because, as counsel for Dr Williams pointed out, the term "fiduciary relationship" defies definition. In Hospital Products Ltd v United States Surgical Corp100 Gibbs CJ said:

I doubt if it is fruitful to attempt to make a general statement of the circumstances in which a fiduciary relationship will be found to exist. Fiduciary relations are of different types, carrying different obligations … and a test which might seem appropriate to determine whether a fiduciary relationship existed for one purpose might be quite inappropriate for another purpose. For example, the relation of physician and patient, and priest and penitent,

may be described as fiduciary when the question is whether there is a presumption of undue influence, but may be less likely to be relevant when an alleged conflict between duty and interest is in question.

As the law stands, the doctor-patient relationship is not an accepted fiduciary relationship in the sense that the relationships of trustee and beneficiary, agent and principal, solicitor and client, employee and employer, director and company and partners are recognised as fiduciary relationships.101 In Hospital Products,102 Mason J pointed out that in all those relationships "the fiduciary acts in a `representative' character in the exercise of his responsibility". But a doctor is not generally or even primarily a representative of his patient.

However, the categories of fiduciary relationship are not closed,103 and the courts have identified various circumstances that, if present, point towards, but do not determine, the existence of a fiduciary relationship. These circumstances, which are not exhaustive and may overlap, have included: the existence of a relation of confidence;104 inequality of

43 ALD 481 at 504

bargaining power;105 an undertaking by one party to perform a task or fulfil a duty in the interests of another party;106 the scope for one party to unilaterally exercise a discretion or power which may affect the rights or interests of another;107 and a dependency or vulnerability on the part of one party that causes that party to rely on another.108

Some aspects of the doctor-patient relationship exhibit characteristics that courts have used to find a fiduciary relationship. For example, from the most mundane consultation with a general practitioner through to the most complicated surgical procedure by a specialist surgeon, a patient is invariably dependent upon the advice and treatment of his or her doctor. Patients also invariably confide intimate personal details about themselves to their doctors. In some circumstances, the dependency of the patient or the provision of confidential information may make the relationship between a doctor and patient fiduciary in nature. But that does not mean that their relationship would be fiduciary for all purposes. As Mason J pointed out in Hospital Products, 109 a person may stand in a fiduciary relationship to another for one purpose but not for others.

In Birtchnell v Equity Trustees, Executors and Agency Co Ltd110 Dixon J said that in "considering the operation of [fiduciary principles], it is necessary to [ascertain] the subject matter over which the fiduciary obligations extend". In the present case, if Dr Williams owed a fiduciary duty to Ms Breen, the duties and obligations which arose from their fiduciary relationship could only come from those aspects of the relationship which exhibited the characteristics of trust, confidence and vulnerability that typify the fiduciary relationship.111 They could only attach in respect of matters that relate to diagnosis, advice and treatment.

A consideration of the fundamental obligations of a fiduciary shows that Dr Williams owed no fiduciary duty to Ms Breen to give her access to the records that he had created. The law of fiduciary duty rests not so much on morality or conscience as on the acceptance of the implications of the biblical injunction that "[n]o man can serve two masters".112 Duty and self-interest, like God and Mammon, make inconsistent calls on the faithful. Equity solves the problem in a practical way by insisting that fiduciaries give undivided loyalty to the persons whom they serve. In Bray v Ford,113 Lord Herschell said:

It is an inflexible rule of a Court of Equity that a person in a fiduciary position, such as the respondent's, is not, unless otherwise expressly provided, entitled to make a profit; he is not allowed to put himself in a position where his interest and duty conflict. It does not appear to me that this rule is, as has been said, founded upon principles of morality. I regard it rather as based on the consideration that, human nature being what it is, there is danger, in such

circumstances, of the person holding a fiduciary position being swayed by interest rather than by duty, and thus prejudicing those whom he was bound to protect. It has, therefore, been deemed expedient to lay down this positive rule.

In the present case, it is impossible to identify any conflict of interest, unauthorised profit or any loss resulting from any breach of duty.

Dr Cashman submitted that Dr Williams had a conflict of interest because in his letter to Ms Breen dated 10 August 1993 he offered to release the records subject to the

condition that Ms Breen release him from any legal claims arising out of the treatment. Dr Cashman contended that this condition evidenced Dr Williams' desire to secure "a legal advantage out of the release of the information" which conflicted with his duty to act at all times in the best interests of the patient. Leaving aside the problem of identifying the basis upon which this duty to act at all times in Ms Breen's best interests is grounded, this argument is without substance. If it were correct, it would lead to the anomalous result that no breach of fiduciary relationship would exist if the doctor unconditionally denied a request for reasonable access, but that a breach of fiduciary obligation would exist if the denial was conditional. This is unacceptable. Duty must precede breach. In Tito v Waddell (No 2),114 Megarry VC pointed out:

If there is a fiduciary duty, the equitable rules about self-dealing apply: but self-dealing does not impose the duty. Equity bases its rules about self-dealing upon some pre-existing fiduciary duty: it is a disregard of this pre-existing duty that subjects the self-dealer to the consequences of the self-dealing rules. I do not think that one can take a person who is subject to no pre-existing fiduciary duty and then say that because he self-deals he is thereupon subjected to a fiduciary duty.

In the present case, there was no breach of fiduciary duty in the conditional denial of access because there was no pre-existing duty on the part of Dr Williams to give access to the records.

It is also impossible to identify any profit that Dr Williams may have derived from the relationship beyond the payment of his authorised professional fees. Nor is the case one where Dr Williams seeks to make or has made a profit from confidential information that he obtained in the course of his relationship with Ms Breen.

The problem of reconciling the alleged fiduciary duty to act in the best interests of Ms Breen with other rights and obligations of Dr Williams and Ms Breen also makes it difficult to see how there could be a fiduciary duty to give access to records relating to her medical treatment. In Hospital Products, Mason J explained the relationship of fiduciary obligations and contractual rights and obligations as follows:115

That contractual and fiduciary relationships may co-exist between the same parties has never been doubted. Indeed, the existence of a basic contractual relationship has in many situations provided a foundation for the erection of a fiduciary relationship. In these situations it is the contractual foundation which is all important because it is the contract that regulates the basic rights and liabilities of the parties. The fiduciary relationship, if it is to exist at all, must accommodate itself to the terms of the contract so that it is consistent with, and conforms to, them. The fiduciary relationship cannot be superimposed upon the contract in such a way as to alter the operation which the contract was intended to have according to its true construction.

The right of access claimed by Ms Breen is not one given by the contract between her and Dr Williams. Nor can it arise from any undertaking, express or implied, by Dr Williams to act as the representative of Ms Breen because no such undertaking was given. Moreover, the contract between the parties gives her no right to or interest in the medical records. They remain the property of Dr Williams.116 Furthermore, a fiduciary duty that Dr Williams would always act in Ms Breen's best interests, which is the foundation of the claim of a fiduciary obligation to provide access to the records, would conflict with the narrower contractual and tortious duty to exercise reasonable care and skill in the provision of professional advice and treatment that Dr Williams undertook.

In addition, Dr Williams is the owner of the copyright in the records. By federal law, ownership of the copyright gives Dr Williams a number of exclusive proprietary rights

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including the right to reproduce the records in any material form.117 He is the beneficial owner of those rights. He does not hold them on trust for Ms Breen. In the absence of an undertaking, express or implied, on the part of Dr Williams to allow her to copy the records, it is difficult to see how Ms Breen could be allowed to copy the records even if she had a right of access to the records.

In our view, there is no basis upon which this court can hold that Dr Williams owed Ms Breen a fiduciary duty to give her access to the medical records. She seeks to impose fiduciary obligations on a class of relationship which has not traditionally been recognised as fiduciary in nature and which would significantly alter the already existing complex of legal doctrines governing the doctor-patient relationship, particularly in the areas of contract and tort. As Sopinka J remarked in Norberg v Wynrib:118

Fiduciary duties should not be superimposed on these common law duties simply to improve the nature or extent of the remedy.

Dr Cashman relied strongly on the decision of the Supreme Court of Canada in McInerney v MacDonald119 to support his contention that Dr Williams owed Ms Breen a fiduciary duty to give her access to the medical records. In McInerney, the Supreme Court held that a doctor owed a fiduciary duty to his or her patient to allow access to medical records, subject to certain conditions. La Forest J, who delivered the judgment of the court, after holding that the doctor owes a duty to his or her patient "to act with utmost good faith and loyalty",120 said:121

The fiduciary duty to provide access to medical records is ultimately grounded in the nature of the patient's interest in his or her records … [I]nformation about oneself revealed to a doctor acting in a professional capacity remains, in a fundamental sense, one's own. The doctor's position is one of trust and confidence. The information conveyed is held in a fashion somewhat akin

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to a trust. While the doctor is the owner of the actual record, the information is to be used by the physician for the benefit of the patient. The confiding of the information to the physician for medical purposes gives rise to an expectation that the patient's interest in and control of the information will continue.

Later his Lordship said:122

The trust-like "beneficial interest" of the patient in the information indicates that, as a general rule, he or she should have a right of access to the information and that the physician should

have a corresponding obligation to provide it. The patient's interest being in the information, it follows that the interest continues when that information is conveyed to another doctor who then becomes subject to the duty to afford the patient access to that information.

However, in this country it is not possible to regard the doctor-patient relationship as one in which the doctor is under a general duty "to act with utmost good faith and loyalty" to the patient. When a medical practitioner undertakes to treat or advise a patient on a medical matter, "[t]he law imposes on a medical practitioner a duty to exercise reasonable care and skill in the provision of professional advice and treatment",123 not a general duty "to act with the utmost good faith and loyalty".

Secondly, with great respect to La Forest J, it does not help analysis of the legal issues in the present class of case to say that the information "is held in a fashion somewhat akin to a trust" or that there is an expectation that the patient's "control of the information will continue". The information is not property.124 Moreover, the only control that a patient has over the information that he or she has given to the doctor is to restrain its improper use.125 Nor is there any trust of it. Equity does not require the doctor to record, account for or even remember the information. Nor can equity at the suit of the patient prevent the doctor from destroying the records that contain the information. The records are the property of the doctor. He or she may be restrained from using the information in them to make an unauthorised profit or from disclosing that information to unauthorised persons. But otherwise the records are his or hers to save or destroy. The idea that a doctor who shreds the records of treatment of living patients is necessarily in breach of fiduciary duties owed to those patients is untenable.

Furthermore, the judgment of La Forest J does not deal with the fact that the medical records of a patient will often, perhaps usually, contain much more than the information that the patient has given to the doctor. In addition to any observations concerning the patient's condition and notes recording treatment and research, the records may contain comments by the doctor about the personality and conduct of the patient. They may also contain information concerning the patient that the doctor has obtained from other sources. The patient has no rights in relation to or control over any information that has not come from him or her. We can think of no legal principle that would give the patient even a faintly arguable case for access to information in the records that is additional to what the patient has given. If the relationship of doctor and patient was a status-based fiduciary relationship in which the doctor was under a general fiduciary duty in relation to all dealings concerning the patient, the patient might be entitled to access to all the information in his or her medical records. But there is no general fiduciary duty.

La Forest J said that the "fiduciary duty to provide access to medical records is ultimately grounded in the nature of the patient's interest in his or her records".126 However, the patient has no legal rights in respect of significant parts of the information contained in medical records. If a patient has a legal right of access to medical records merely because he or she has given personal and confidential information to a doctor, it would seem to follow that journalists, accountants, bank officers and anybody else receiving personal and confidential information always had a fiduciary duty to give access to their records to the person who gave that information.127

Thirdly, the Canadian law on fiduciary duties is very different from the law of this country with respect to that subject. One commentator has recently pointed to the "vast differences between Australia and Canada in understanding of the nature of fiduciary obligations".128 One significant difference is the tendency of Canadian courts to apply fiduciary principles in

an expansive manner so as to supplement tort law and provide a basis for the creation of new forms of civil wrongs.129 The Canadian cases also reveal a

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tendency to view fiduciary obligations as both proscriptive and prescriptive.130 However, Australian courts only recognise proscriptive fiduciary duties. This is not the place to explore the differences between the law of Canada and the law of Australia on this topic. With great respect to the Canadian courts, however, many cases in that jurisdiction pay insufficient regard to the effect that the imposition of fiduciary duties on particular relationships has on the law of negligence, contract, agency, trusts and companies in their application to those relationships.131 Further, many of the Canadian cases pay insufficient, if any, regard to the fact that the imposition of fiduciary duties often gives rise to proprietary remedies that affect the distribution of assets in bankruptcies and insolvencies.

In this country, fiduciary obligations arise because a person has come under an obligation to act in another's interests. As a result, equity imposes on the fiduciary proscriptive obligations — not to obtain any unauthorised benefit from the relationship and not to be in a position of conflict. If these obligations are breached, the fiduciary must account for any profits and make good any losses arising from the breach. But the law of this country does not otherwise impose positive legal duties on the fiduciary to act in the interests of the person to whom the duty is owed.132 If there was a general fiduciary duty to act in the best interests of the patient, it would necessarily follow that a doctor has a duty to inform the patient that he or she has breached their contract or has been guilty of negligence in dealings with the patient. That is not the law of this country.

In Australia, therefore, McInerney cannot be regarded as a persuasive authority. In this country a court cannot use the law of fiduciary duty to provide relief to Ms Breen which, if granted, would have the effect of imposing a novel, positive obligation on Dr Williams to maintain and furnish medical records to Ms Breen. It follows that Dr Williams does not owe Ms Breen any fiduciary duty to give Ms Breen access to the medical records that relate to his treatment of her.

The “right to know”

Dr Cashman contended that the law in Australia governing the doctor-patient relationship has moved to or is moving towards a recognition of the patient's “right to know” and that this was a reason why the court should hold that a patient has a right of access to medical records concerning that person. He argued, relying particularly on the decision of this court in Rogers v Whitaker,133 that this movement is recognisable in the law in five ways: an acceptance of the principle of personal inviolability; a rejection of a paternalistic approach which had been previously accepted; the rejection of the notion that the patient's interests are to be determined by standards exclusively fixed by the medical profession; the imposition of judicially imposed standards; and the acceptance of patient autonomy. Dr Cashman did not contend, however, that this “movement” in the law of itself gave Ms Breen the right of access for which he argued. Rather, he suggested that it advanced the validity of his other arguments.

While recent decisions of Australian courts have rejected the attempt to treat the doctor-patient relationship as basically paternalistic, it would require a quantum leap in legal doctrine to justify the relief for which Dr Cashman contends. Rogers took away from the medical profession in this country the right to determine, in proceedings for negligence, what amounts to acceptable medical standards. But the decision also rejected

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the notion of “the patient's right of self-determination” as providing any real assistance in the “balancing process that is involved in the determination of whether there has been a breach of the duty of disclosure”.134

Any change in the law must be for parliament

No doubt there are people in this country who think that a patient should have an unrestricted right of access to medical records that concern that patient. Many others, Ms Breen among them, no doubt think that a patient should have access to such records, subject to limited exceptions. Perhaps only a very small minority of persons in Australia would think that in no circumstances should patients have access to information contained in their medical records. But absent a contractual right, the common law of Australia does not give a patient a right to have access to records, compiled by a medical practitioner, which relate to that patient. Nor, for the reasons that we have given, is it possible for this court to develop existing principles to create such a right.

Advances in the common law must begin from a baseline of accepted principle and proceed by conventional methods of legal reasoning. Judges have no authority to invent legal doctrine that distorts or does not extend or modify accepted legal rules and principles. Any changes in legal doctrine, brought about by judicial creativity, must “fit” within the body of accepted rules and principles. The judges of Australia cannot, so to speak, “make it up” as they go along. It is a serious constitutional mistake to think that the common law courts have authority to “provide a solvent”135 for every social, political or economic problem. The role of the common law courts is a far more modest one.

In a democratic society, changes in the law that cannot logically or analogically be related to existing common law rules and principles are the province of the legislature. From time to time it is necessary for the common law courts to reformulate existing legal rules and principles to take account of changing social conditions. Less frequently, the courts may even reject the continuing operation of an established rule or principle. But such steps can be taken only when it can be seen that the “new” rule or principle that has been created has been derived logically or analogically from other legal principles, rules and institutions.

In the present case, it is not possible, without distorting the basis of accepted legal principles, for this court to create either an unrestricted right of access to medical records or a right of access, subject to exceptions. If change is to be made, it must be made by the legislature.

Order

The appeal should be dismissed.

Gummow J.

Introduction

The respondent is a medical practitioner. In 1978 he was consulted by the appellant and she was treated by him. In these proceedings, the appellant seeks to establish and enforce her legal entitlement to have access, for any purpose she may have, to records in the possession, custody or control of the respondent which contain information relating to the provision of treatment or advice to her by the respondent. In particular, the appellant asserts a legal right, upon reasonable request, to be given access by the respondent to examine and to obtain copies of those records, whether by copying herself or by provision of copies to her at reasonable cost.

Broadly, the respondent's position is to accept that the patient or former patient has a right to be informed of all relevant factual information contained in the medical records of the patient but to deny any entitlement in the patient to examine those records or to obtain copies.

The respondent submits that his stance is in accordance with the relevant resolution of the Federal Council of the Australian Medical Association (the AMA). At its meeting on 29 and 30 October 1993, the AMA resolved as follows:

That the AMA endorses the following guidelines on patients' access to records concerning their medical treatment:

The patient has a right to be informed of all relevant factual information contained in the medical record, but all deductive opinion therein recorded remains the intellectual property of the doctor or doctors contributing to, or recognised employing hospital or other organisation maintaining the record. Where appropriate, such deductive opinion may be separately recorded.

On request, the patient should be informed of any or all content of the following sections of the medical record:

History

Physical Examination Findings

Investigation Results

Diagnosis (Diagnoses)

Proposed Management Plan

The patient should be allowed access to any other contents of the medical record (such as reports by specialists) beyond the materials above specified only at the discretion of the doctor or doctors who completed such additional section or sections, or by hospital administration after consultation with the doctor(s) who completed such section or sections, or as the result of a legal requirement.

Doctors and hospitals are entitled to recoup their costs of providing information contained in a medical record from the patient or other legally authorised requestor [sic] of the information [emphasis added].

The facts and the history of the proceedings

In October 1977, the appellant underwent a surgical procedure by which a small silicone implant was inserted in her left breast and a larger implant in her right breast. The operation was performed by another medical practitioner. In August 1978, the appellant consulted the respondent, Dr Williams. Dr Williams has practised in Sydney since 1974 as a consultant surgeon specialising in plastic surgery. The appellant consulted him with respect to both her condition following the surgical procedure of October 1977 and some facial scarring. There were two further consultations concerning both matters in August and September 1978. In November of that year the respondent operated on the appellant under general anaesthetic to perform a bilateral capsulotomy for the compression of hard capsules which had developed since the earlier surgical procedure. The respondent then had no further consultations with the appellant until May 1983. She then wrote to him concerning further plastic surgery, including removal of the breast implants and their replacement with larger implants. Correspondence concerning this possible further treatment continued until September 1983.

In 1984 the appellant noticed the development of a lump under her left breast. This was diagnosed as a leakage of silicone gel from the breast implant and an operative procedure was performed by another medical practitioner.

It is the practice of the respondent to maintain a file with respect to each patient. Usually this will include handwritten notes containing a variety of information bearing upon such matters as the description provided by the patient of the patient's medical condition, the circumstances in which the patient was referred to the respondent, the respondent's notes of his observations upon examination of the patient and conclusions in relation thereto (including what the respondent called his "medical musings" about the

patient's condition), and communications with other practitioners treating the patient and with the family and friends of the patient. Further, where the respondent has reason to believe or suspect that there may be criticism of his treatment or advice, he keeps short notes of any information or developments which may bear upon any such future dispute. All of these notes are written in an abbreviated fashion which conveys meaning to the respondent but which might be difficult for others to follow.

In 1993, the appellant, with many others from Australia, the United States and other countries, became involved in litigation against various parties, including the manufacturer of the breast implants, Dow Corning Corporation. Numerous "class actions" had been commenced in United States District Courts against 16 manufacturers of silicone gel breast implants, including Dow Corning Corporation. On 25 June 1992, the Judicial Panel on Multidistrict Litigation ordered that all of these actions be transferred to the United States District Court for the Northern District of Alabama for coordinated or consolidated pre-trial proceedings.136 By orders of that court made 1 September 1994, Australian litigants were excluded from a proposed settlement but the court afforded them an opportunity to "opt in". It was a term of the "opting in" procedure that each claimant, including the present appellant, file with the United States court copies of medical records in support of any claim they wished to propound.

It was in this setting that the appellant commenced a proceeding in the Equity Division of the Supreme Court of New South Wales. The appellant failed at first instance before Bryson J. The crucial passage in his Honour's reasoning was as follows:

The [respondent] was not made the [appellant's] medical adviser for the purpose of making him a collector or repository of information for the [appellant] to have available to her for whatever purposes she chose. Collecting and retaining information by him was a purpose of the relationship, but it was a subsidiary purpose, to lead only to medical advice and treatment to be administered by him or on his referral. It is not in my judgment unconscionable for the [respondent] to retain the information and keep it to himself except when and in so far as it is required for the purpose of treatment by him. A doctor is not put in a position to receive, compile and retain information for the very purpose of having it available when it is required and for whatever purpose it is required.

An appeal to the Court of Appeal was dismissed by a majority (Mahoney and Meagher JJA, Kirby P dissenting).137

In his dissenting judgment, Kirby P would have granted the appellant relief in these terms:138

(a)

declare that the appellant has a right, upon request, to be given reasonable access by the respondent to examine, copy and/or at reasonable cost, to obtain [copies] of records or information concerning her, created or obtained by the respondent in the course of providing medical treatment or advice to her, being recorded in the medical records or in other tangible form in the possession, custody or control of the respondent, subject [to] the exclusion therefrom of such records or information as the respondent may lawfully exclude from such access;

(b)

declare that the respondent may lawfully refuse to provide access to the appellant to records and information in his possession:

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(i)

created or obtained solely for the benefit of the respondent in the conduct of his practice or in respect of which he may lawfully claim legal professional or other privilege;

(ii)

the disclosure of which the respondent reasonably believes is likely to cause serious harm to the physical or mental health of the appellant; and

(ii)

the disclosure of which would found an action for breach of confidence;

(c)

order that the respondent provide the appellant with reasonable access to records or information in his possession, custody or control as aforesaid concerning the appellant, subject to the exclusion therefrom of records and information in respect of which the respondent has a lawful excuse for not providing access.

The three matters identified in the second declaration respond to the contentions advanced for Dr Williams that the imposition of a general obligation of disclosure would impinge upon his right to legal professional privilege, could conflict with an obligation of confidence owed by him to third parties and may require disclosure of material likely to cause harm to the health of the patient. The last-mentioned matter has been described as the "therapeutic privilege".

Discovery

On its face, the relief which Kirby P would have given, and for which the appellant contends in this court, bears some resemblance to an order for particular discovery which might have been made in aid of the "opt in" procedure laid down by the United States District Court. The question is whether, in its inherent jurisdiction as a court of equity, the Supreme Court would have had the authority to make such an order, if its jurisdiction in that regard had been invoked by the appellant. The contrary was not asserted in the submissions to this court.

In dealing with bills of discovery under the old procedure, Story wrote:139

[I]t constitutes no objection to a bill of discovery that it is to assist proceedings in a court which sits in a foreign country, if in amity with that where the bill is filed; for it is but a just exercise of that comity which the mutual necessities and mutual convenience of all nations prescribe in their intercourse with each other.

Hare,140 Mitford141 and Chancellor Kent142 were of the same view. Later English decisions, notably those of Shadwell V-C in Bent v Young143 and of Kay J in Dreyfus v

Peruvian Guano Co,144 appeared to decide that the Court of Chancery and then the High Court of Justice would not entertain an action for discovery in aid of proceedings in a foreign court, at least unless it appeared that the foreign suit had been instituted, discovery was essential to it and the foreign court could not compel the discovery sought.145 It was also suggested in Bent v Young146 that "in the contemplation of the Court of Chancery, every foreign court is an Inferior Court" in the same way as in England the ecclesiastical courts were treated as courts inferior to the Court of Chancery. However, this reasoning was decisively rejected in the United States, notably in the judgment of Field J in Post v

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Toledo, Cincinnati and St Louis Railroad Co.147 His Honour referred to earlier United States authority, such as the decision of Chancellor Kent in Mitchell v Smith148 and stated that the suggestion that all foreign courts should be treated as having the same status as a domestic inferior court did "not require serious consideration".149

Moreover, more recent developments in England itself have revived, and perhaps extended, what was the previous jurisdiction to entertain bills for discovery. In Norwich Pharmacal Co v Customs & Excise Commissioners,150 the House of Lords held that the proposition that discovery did not lie against a "mere witness" did not bar an action for discovery for disclosure to the plaintiff of the identity of a wrongdoer in whose tortious acts the respondent innocently had become involved. That decision was applied in British Steel v Granada Television.151 More recently, in Mercantile Group (Europe) AG v Aiyela,152 Hoffmann LJ, who gave the leading judgment in the Court of Appeal, held that discovery was not limited to finding out the identity of a tortfeasor. His Lordship referred to Bankers Trust Co v Shapira153 where discovery was ordered against a bank which, innocently, had received the proceeds of a fraud, the purpose of the discovery being to trace what had happened to the money.

Accordingly, it may be accepted that it would have been within the inherent jurisdiction of the Supreme Court, as a court of equity, to make an order for particular discovery, in terms resembling the relief which Kirby P would have granted. It would have been no sufficient objection to the existence of such jurisdiction that the relief was sought to assist the appellant in complying with "opt in" procedures laid down by the United States District Court, or that the relief was sought not against a party to the United States litigation but against a stranger to it. So much appeared to be common ground in this court.

One consideration which would arise when deciding to grant such relief would be the availability of an alternative compulsory court process. One such possibility would have been the issue of Letters Rogatory by the United States District Court. Other Australian litigants who are parties to that proceeding did take this course. In the present case, Kirby P154 observed that, while orders had been made by judges of the Supreme Court of New South Wales in response to such Letters Rogatory obtained by other litigants, the costs, delays and complications of that procedure were significant.

However, when the matter was raised at the hearing of the appeal in this court, the appellant expressly disavowed any reliance upon the law as to discovery in aid of a foreign proceeding as a foundation for the relief she seeks.

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Moreover, the United States proceeding appears to be at a standstill. This court granted special leave to appeal from the decision of the Court of Appeal on 12 May 1995. At the hearing of the appeal, the court was informed that, on 15 May 1995, certain steps were taken in respect of the defendant in the United States proceeding, under Ch 11 of the United States

statute the Bankruptcy Reform Act of 1978. These had the effect of staying the orders made by the District Court on 1 September 1994.155

The right asserted by the appellant

It was submitted to this court that the objective of the proceeding in this country was not only to obtain assistance, as described, in aid of the United States action but also "to have the information relating to [the appellant's] personal health for her information" and, "to ensure that she is able to make decisions regarding her future treatment".

Further, in argument, the appellant shifted ground and asserted that the right for which she contended arose and was enforceable regardless of what, if any, purpose moved her to assert it. Accordingly, the appellant contends that she has what one might describe as a "free-standing" legal right which is exercised or vindicated by declaratory and other relief in terms as specified by Kirby P and set out earlier in these reasons.

The appellant argued unsuccessfully in the Court of Appeal156 that there was a legal doctrine, "the right to know", which provided, by itself, sufficient support for her claim. That submission was abandoned in the course of argument before this court.

By letter dated 10 August 1993, addressed to the appellant, the respondent replied to a request from her solicitors for copies of all her medical records by saying, in part:

As they well know, it is a longstanding legal tradition in this country that such records are the doctor's property, an aide memoire to his treatment of the patient, and may only be released on production of a court subpoena.

Accordingly the advice which I have received from my medical defence legal advisers is that this situation still holds, but that they would be very happy for me to release your records, were you to supply me with a document which would release me from any claim that might arise in relation to my treatment of you.

This was unacceptable to the appellant, if only by reason of the condition requiring provision of a release by her of any claims she might have in respect of her treatment by the respondent. Later, at the trial in the Equity Division, counsel for Dr Williams announced to the court:

I am instructed to make an offer in open court which is for the [respondent] to provide a report in writing to the [appellant] as to the contents of the documents which are comprised in the document marked 1 for identification relating to any of the following; history, physical examination findings, investigation results, diagnosis, proposed management plan, treatment or advice furnished to the [appellant].

The tenor of this offer is that the report was to convey information, but not to set out in full the text of any documents held by the respondent. Thus it still was unacceptable to the appellant.

The material marked "MFI1", referred to by counsel for the respondent, was Dr Williams' file. For reasons which do not appear, this was never tendered in evidence. The result was that the primary judge was left to infer from other evidence the contents

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of the file. On that footing, Bryson J found that the file contained handwritten notes of Dr Williams and correspondence with the patient and that there might also be included letters reporting to referral doctors, hospital advice slips, communications with the New South

Wales Medical Defence Union and photographs of the patient taken to assist diagnosis and treatment.

This absence of a clear and unequivocal finding as to the identity and contents of the records held by the respondent has a significance for the repeated reference in the appellant's submissions to this as a “test case”. The consequence is to impede the effective operation of the doctrine of precedent which seeks to provide an appropriate measure of certainty in the law. Rather, what is involved is an attempt to establish an abstract principle of law which is not derived from a firm foundation of fact provided in the case.

However, the appellant asserts a right given to her by the law and the respondent denies the existence of that right. We should, therefore, determine that controversy.

Contract

The relationship between medical practitioner and patient may engage the law in various respects. Traditionally, there has been a contractual relationship, the medical practitioner performing services in consideration for fees payable by the patient.157 That established pattern now may require adjustment to accommodate wholly or partly state operated or financed health schemes, established by statute. The “bulk-billing” provisions of the Health Insurance Act 1973 (Cth), considered in Edelsten v Health Insurance Commission,158 provide an example of this.

The appellant, as I understand it, submitted that the right for the existence of which she contended was a term of contract with the respondent. There was exiguous evidence as to the form taken by, and the express terms of, any contract between the appellant and the respondent for the provision of medical advice and treatment. This makes it difficult for the appellant to succeed on a contention that the term in question gives effect to an apparent underlying intention of the parties as to the provision of business efficacy to their contract. Where, as here, the contract was not reduced to any complete written form, the question is whether the implication of the term was necessary for the reasonable or effective operation of the contract in the circumstances of the case; only where this can be seen to be so will the term be implied.159

As I have indicated, the appellant asserts not merely a term which confers upon the appellant a right to be informed by the respondent, on reasonable request, of relevant factual material contained in her medical records. If that was all that was in the case, then the court might well accept the existence of such a term. As I understand his position adopted in this court, the respondent would not now deny its existence. Moreover, as time goes on, the ground will strengthen for the importation of a term in contracts between doctor and patient which accords with the AMA resolution set out earlier in these reasons and which may by then have become customary, in the sense described in Con-Stan

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Industries of Australia Pty Ltd v Norwich Winterthur Insurance (Australia) Ltd.160 But the appellant goes further. She claims an entitlement to examine her records and to obtain copies.

In my view, it cannot be said that a term in that form is necessary for the reasonable or effective operation of the contract. A term in the form urged by the appellant is not to be imported to give effect to a tacit intention of the parties in the circumstances of the case.

Nor is such a term imported by law in all contracts of a particular class, namely the provision of treatment or advice by medical practitioner to patient, and in the absence of an expression of contrary intent. Certainly, it has been held in England that the law implies a term into the contract between medical practitioner and patient that the former is to keep the affairs of the

latter secret and not disclose them without just cause.161 However, it could not be said, as would need to be the case, that, unless the term for which the appellant contends were implied as a matter of law, the enjoyment of the rights conferred upon the patient by the contract with the medical practitioner would, or could, be rendered nugatory, worthless or, perhaps, be seriously undermined.162

"Informed consent"

Reference is made in submissions to statements of principle by this court in Rogers v Whitaker163 as supportive of a doctrine of "informed consent". That case was an action in negligence. The court was considering the duty of a medical practitioner to exercise reasonable care and skill in provision of professional advice and treatment. The particular issue was whether the appellant's failure to advise and warn the respondent of the risks inherent in a particular operation undergone by her constituted a breach of that duty. The court determined that, except in the case of an emergency or where disclosure would prove damaging to the patient (the so-called "therapeutic privilege"), a medical practitioner has a duty to warn the patient of a material risk inherent in proposed treatment. Further, risk is material where, in the circumstances of a particular case, a reasonable person in the position of the patient, if warned of the risk, would be likely to attach significance to it or where the medical practitioner is or should reasonably be aware that a particular patient, if warned of the risk, would be likely to attach significance to it.

This formulation of principle was made for the purposes of the tort of negligence, and the elucidation of the overall duty of care owed to the patient by the medical practitioner. The court observed164 that, in the context in which it was considering the matter, nothing was to be gained by reiterating expressions used in American authorities such as "the patient's right of self-determination" or even "the oft-used and somewhat amorphous phrase `informed consent' ". The court pointed out that the phrase "informed consent" is apt to mislead as it suggests a test of the validity of the patient's consent and that, moreover, consent is relevant to actions framed in trespass, not in negligence.

To this it may be added that in fiduciary law "informed consent" is an answer to circumstances which otherwise indicate disloyalty, not a mainspring of equitable liability. In the United States, the phrase "informed consent" in this area of legal discourse appears to represent some assumed synthesis between the tort of negligence and principles of fiduciary duty law.165 The Privy Council and House of Lords recently have cautioned

against such processes.166 There is a fundamental principle that it is an answer to a claim against an erring fiduciary that the plaintiff gave an informed consent, after full and frank disclosure of all material facts,167 to the alleged breach of duty. However, it seems that, in the United States, this is translated into a "free-standing" action for damages brought against the medical practitioner by the patient for failure to treat the patient only with the "informed consent" of the patient.168

The law in Australia has been established in Rogers v Whitaker in the manner I have described. It is impossible to extract from the formulation of principle in that decision support for the existence of the legal right asserted by the appellant in this case. Indeed, and in any event, the appellant does not seek a remedy against the respondent for failure to treat her only with her fully informed consent. She has no such complaint against the respondent. Rather, she claims the legal right to inspect and take copies of records.

Property rights

The appellant also sought to draw support for the right she asserts from a complex of equitable institutions and doctrines dealing with fiduciary duty, confidential information, undue influence, and with unconscientious transactions of the nature considered in such authorities as Louth v Diprose.169

To some extent these submissions reflect an imperfect understanding of some basic matters of the law of personal property. Other submissions concern classification as "property" of the information contained in the records in question. As the submissions for the appellant appear to reflect some confusion of thought, it is appropriate, before proceeding further, to draw several basic distinctions.

First, as I understand the submissions, the appellant did not contend before us, and she had not contended before the Court of Appeal,170 that she owned the relevant records "as such". That concession (as the Court of Appeal agreed)171 was correctly made. The documents in question, including any photographs, are chattels, ownership and the right to exclusive possession of which appear to be enjoyed by the respondent. Access to those records would be an incident of those rights. They would be protected against invasion by the law of tort, in particular by actions for detinue and conversion. Thus, in Moorhouse v Angus & Robertson (No 1) Pty Ltd,172 McLelland J held that a cause of action in detinue had been established by an author against his publishers by reason of their failure to comply with his demand for the return of his original manuscript.

Again, in New York, it has been held that the ownership of the medical files of a deceased physician passes to the executor, the property therein having been vested in the

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physician, not the patients.173 Further, a former patient of several hospitals in New York wherein she had been a voluntary patient for treatment for mental illness was held to lack sufficient property interest in medical records relating to her treatment for protection, under the Fourteenth Amendment to the United States Constitution, against deprivation of property without due process of law by reason of refusal of the hospitals to grant her access to the records.174

Secondly, the appellant's submissions gave insufficient allowance to the operation in this field of copyright law, a matter of federal statute. The composition by the medical practitioner of the material shown on the records may have involved the authorship by him of what, while not of literary quality, were nevertheless literary works for the purposes of copyright law. This would vest in him various exclusive proprietary rights, including that to reproduce the work in a material form.175 In Pacific Film Laboratories Pty Ltd v FCT,176 Windeyer J referred to the fundamental distinction between copyright as incorporeal property and property in the material thing which is the subject of the copyright, the essence of the former being the power to prevent the making of a reproduction in material form. His Honour referred to authorities, including Re Dickens.177 This illustrates the distinction. On the proper construction of his will, Charles Dickens bequeathed the manuscript of an unpublished work to his sister-in-law and his residuary estate, including the copyright in the unpublished work, to his children. Ownership of the manuscript would not, of itself, carry with it the right to publish it and to reproduce it.

It is unlikely that the medical practitioner would have made the literary works in pursuance of the terms of his employment by the patient under what was classified as a contract of service, so that the patient was the owner of the copyright.178 Ownership of the copyright in any photographs, as artistic works179 would, pursuant to s 35(5) of the Copyright Act 1968 (Cth), vest in the patient only if within the meaning of that provision the patient had made for

valuable consideration an agreement for the taking of the photographs and they were taken in pursuance of that agreement.

The copyright of the respondent would not be infringed by anything done for the purposes of a judicial proceeding.180 Nor would it be an infringement to act pursuant to a licence or permission (which might be express or implied).181

However, the circumstances of the present case, as disclosed in the evidence, do not provide support for the existence of any copyright licence or consent given to the appellant either expressly or by implication. Nor does it appear that such a licence is implied in the contract between medical practitioner and patient as a matter of law in the sense I have described earlier in these reasons.

A further distinction is to be drawn between, on the one hand, property in the physical material on which the records appear, and any literary work which might be represented in the records in question and, on the other hand, a third possible source of juristic rights.

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This may be sought in the information which might be conveyed to the reader of those records.182 However, in FCT v United Aircraft Corp,183 Latham CJ said:

Authorities which relate to property in compositions, etc, belong to the law of copyright and have no bearing upon the question whether knowledge or information, as such, is property. It is only in a loose metaphorical sense that any knowledge as such can be said to be property.

Those remarks are to be understood in the light of developments, largely since they were made, in equitable jurisdiction. In equity, misuse of confidential information may be restrained. The subject matter is not confined to trade secrets. It extends to information as to the personal affairs and private life of the plaintiff, and in that sense may be protective of privacy.184

That such equitable jurisdiction exists has been accepted on at least two occasions in appeals to this court.185 Further, the outcome before Mason J in Commonwealth v John Fairfax & Sons Ltd186 illustrates that a claim for copyright infringement and for abuse of confidence made in respect of the one factual matrix may fail as to one and succeed as to the other.

A medical practitioner has been said to be under an obligation in equity not to disclose confidential information concerning a patient which is learned in the course of professional practice, an obligation from which the medical practitioner may be released only with the express or implied consent of the patient.187 But, in the present case, there is no apprehended breach of an obligation of confidence owed by the respondent to the appellant.

Nor is it acceptable to argue that, because, in some circumstances, the restraint of an apprehended or continued breach of confidence may involve enjoining third parties (as Gaudron J explained in Johns v Australian Securities Commission),188 it follows that the plaintiff who asserts an obligation of confidence therefore has proprietary rights in the information in question which in turn found a new species of legal right. In my view there is no substance in what appeared to be the appellant's submission that the existence of an obligation of confidence owed to her by the respondent brought with it a proprietary right which founded her claim to the particular relief she seeks in this litigation.

Canadian authority

The appellant also relied upon a decision of the Supreme Court of Canada, the reasoning in which appears, at least in part, to have been informed by considerations of property law. The decision is McInerney v MacDonald.189 The decision in that case was:190

In the absence of regulatory legislation, the patient is entitled, upon request, to inspect and copy all information in the patient's medical file which the physician considered in administering advice or treatment. Considering the equitable base of the patient's entitlement, this general rule of access is subject to the superintending jurisdiction of the court. The onus is on the physician to justify a denial of access.

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However, the precise issue in the case was somewhat narrower and it is to this that one should have regard. The outcome of the litigation was to uphold the order of the primary judge in the Court of Queen's Bench of New Brunswick. This was that Dr McInerney provide to Mrs MacDonald, her patient, copies of all documents which she had received from five other physicians who had previously treated the respondent, together with the written opinions as to the respondent's medical condition prepared by consultants at the request of the other physicians. Dr McInerney had cooperated with the patient to the extent of providing, for a fee, copies of notes, memoranda and reports prepared by her but she refused to deliver copies of the other documents on the footing that they were the property of the other physicians and it would not be ethical for her to release their reports and records.191

By the time the case reached the Supreme Court of Canada, Mrs MacDonald had obtained copies of all the material in question, so that she had no interest in contesting the appeal.192 Her counsel appeared as amicus curiae only.

The judgment of the Supreme Court of Canada was delivered by La Forest J. His Lordship began by defining in broad terms the “central issue”, as being whether, in the absence of legislation, a patient is entitled, upon request, to obtain copies of the patient's medical records.193 La Forest J dealt as follows with what he identified as the nature of the interest of the patient in his or her records:194

As discussed earlier, information about oneself revealed to a doctor acting in a professional capacity remains, in a fundamental sense, one's own. The doctor's position is one of trust and confidence. The information conveyed is held in a fashion somewhat akin to a trust. While the doctor is the owner of the actual record, the information is to be used by the physician for the benefit of the patient. The confiding of the information to the physician for medical purposes gives rise to an expectation that the patient's interest in and control of the information will continue.

…

The trust-like “beneficial interest” of the patient in the information indicates that, as a general rule, he or she should have a right of access to the information and that the physician should have a corresponding obligation to provide it. The patient's interest being in the information, it follows that the interest continues when that information is conveyed to another doctor who then becomes subject to the duty to afford the patient access to that information.

These passages should be read having in mind the particular issue which had been in dispute, not the provision by Dr McInerney of records prepared by her, but delivery of reports and records prepared by other physicians but which had come into her possession. That, as this appeal was presented, is not the present dispute. In any event, I would, with respect to the reasoning of La Forest J, not share the view that a proprietary analysis of the equitable obligation of confidence assists in this field. The appellant does not seek an order for delivery up of the records in question in aid of any allegation of abuse of confidence against Dr Williams.

British authority

The appellant also relies upon what was submitted to be a common law right established by the decision of the English Court of Appeal in R v Mid Glamorgan Family Health Services.195 This was a proceeding for judicial review of decisions made by the two respondents which were regional health authorities established pursuant to legislation. The

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Court of Appeal held that the health authorities, as the owners of the medical records of the patient, were obliged to administer their property in accordance with their public purposes. The fulfilment of this duty meant that the authorities were bound to deal with the records in the same way as a private physician.196 It followed from this that the authorities might deny a patient access to medical records if it was in the best interests of the patient to do so.

The authorities had refused to make voluntary disclosure of any of the records direct to the plaintiff on the footing that to do so would be detrimental to him and not in his best interests. However, the authorities had offered the sight of the records to the applicant's medical adviser. The Court of Appeal held that the taking of that step by the authorities was all that was necessary to comply with their duties to the applicant. The particular issue which concerned their Lordships was identified by Nourse LJ in the opening paragraphs of his judgment197 as being whether a doctor or health authority, as the owner of the medical records of a patient, was entitled to deny the patient access to them on the ground that their disclosure would be detrimental to the patient. The copying, in contrast to inspection, of the records does not appear to have been sought. The effect of the decision in Mid Glamorgan Family Health Services is that, whatever otherwise might have been the rights of the patient, the health authorities, as owners of the records, might deny the patient access to them if it was in the best interests of the patient to do so, for example, if disclosure would be detrimental to the health of the patient.

Sir Roger Parker observed198 that the circumstances in which a patient or former patient was entitled to demand access to the medical history as set out in the records would be infinitely various so that it was neither desirable nor possible to set out the scope of the duty to afford access or the scope of the patient's rights to demand access. The decision of the English Court of Appeal thus does not provide any adequate foundation for the existence of the particular common law right which the appellant propounds in this appeal. One commentator identified an “absence of solid legal foundations in the judgments for the right to access”.199

In Scotland there is authority to the contrary of the English decision. One of the submissions in Boyle v Glasgow Royal Infirmary and Associated Hospitals200 was that the second pursuer was legally entitled at any time to see the records of her hospital treatment and, if necessary, to recover the complete record of any treatment received by her. This submission was rejected by the Court of Session. Lord Cameron said, in words indicative of reasoning akin to that of Bryson J in the present case:201

The records of a patient's condition and treatment are not kept for the purpose of being made available to the patient on call, but so that a full and complete record of that patient's condition, treatment and response or reaction to treatment may be kept. They may be valuable as an adjunct to research and the advancement of medical science, they may be valuable for further treatment of the patient in other or recurrent circumstances, and it is obvious that those who make or keep them must be wholly free to state fully and frankly what they have to note, express or record.

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Equitable doctrines — fiduciary duty

I have dealt with the reliance by the appellant upon contract. The appellant, as I have indicated, also relies upon incidents of the relationship between medical practitioner and patient which may attract equitable intervention. In my opinion, there is no substance in these submissions.

However, in what follows I am not to be understood as supporting the existence of any necessary antipathy between concurrent contractual and fiduciary obligations. The law of partnership is an obvious example of such a concurrence. The mere presence of a contract does not exclude the coexistence of concurrent fiduciary duties and the contract may, in particular circumstances, provide the occasion for their existence.202 That is not to deny that a contractual term may be so precise in its regulation of what a party may do that there is no scope for the creation of a fiduciary duty.203

This is not the case of any improvident transaction between medical practitioner and patient which is the product of unconscientious pressure or influence exerted upon the patient. In Johnson v Buttress,204 Dixon J said that a physician must justify the receipt of a substantial benefit from the patient, in the same way as must a solicitor in respect of the client and a guardian from the ward. His Honour said205 that, where the parties antecedently stood in a relation which gave one an authority or influence over the other from the abuse of which it is proper that there should be protection:

the party in the position of influence cannot maintain his beneficial title to property of substantial value made over to him by the other as a gift, unless he satisfies the court that he took no advantage of the donor, but that the gift was the independent and well-understood act of a man in a position to exercise a free judgment based on information as full as that of the donee.

What is there said does not directly bear upon the situation with which this appeal is concerned. However, Dixon J went on, in the same passage, to observe that the doctrine which throws upon the recipient the burden of justifying such a transaction rests upon a particular principle. Of that principle, his Honour said:206

It applies whenever one party occupies or assumes towards another a position naturally involving an ascendancy or influence over that other, or a dependence or trust on his part. One occupying such a position falls under a duty in which fiduciary characteristics may be seen. It is his duty to use his position of influence in the interest of no one but the man who is governed by his judgment, gives him his dependence and entrusts him with his welfare [emphasis added].

This reasoning was further developed by La Forest J in the following passage from his recent judgment in Hodgkinson v Simms:207

The concepts of unequal bargaining power and undue influence are also often linked to discussions of the fiduciary principle. Claims based on these causes of action, it is true, will often arise in the context of a professional relationship side by side with claims related to duty of care and fiduciary duty … Indeed, all three equitable doctrines are designed to protect vulnerable parties in transactions with others. However, whereas undue influence focuses on the sufficiency of consent and unconscionability looks at the reasonableness of a given transaction, the fiduciary principle monitors the abuse of a loyalty reposed … Thus, while the existence of a fiduciary relationship will often give rise to an opportunity for the fiduciary to gain an advantage through

undue influence, it is possible for a fiduciary to gain an advantage for him- or herself without having to resort to coercion … Similarly, while the doctrine of unconscionability is triggered by abuse of a pre-existing inequality in bargaining power between the parties, such an inequality is no more a necessary element in a fiduciary relationship than factors such as trust and loyalty are necessary conditions for a claim of unconscionability [emphasis added].

Conformably with the reasoning of Gibbs CJ and Brennan J in Daly v Sydney Stock Exchange Ltd,208 the relationship between medical practitioner and patient who seeks skilled and confidential advice and treatment is a fiduciary one. That will be so regardless of whether it is because the relationship between the parties is one which gives the medical practitioner a special opportunity to affect the interests of the patient who is vulnerable to abuse by the fiduciary of his position, or because the medical practitioner undertakes to exercise professional skill for the benefit of the patient, and particular reliance is placed upon the medical practitioner by the patient.209

Advice given by the physician to the patient involves specialised knowledge and matters of skill and judgment, which render the advice difficult, if not impossible, of objective and unassisted assessment by the patient. Hence the particular reliance placed upon the physician. In a real sense, especially if invasive procedures upon the person of the patient are involved, the patient has delegated control to the person providing health care. Further, for the patient to obtain the benefit sought from the relationship the patient often must reveal confidential and intimate information of a personal nature to the medical practitioner. Finally, the efforts of the medical practitioner may have a significant impact not merely on the economic but upon the fundamental personal interests of the patient. These considerations, as Professor De Mott has pointed out, serve to emphasise why there is a fiduciary element in the relationship between medical practitioner and patient.210

However, to reach that stage of reasoning is not to attain the destination desired by the appellant. First, it is necessary to consider not only whether the relationship between the parties is such as to give rise to fiduciary obligations but also the extent of those obligations in the particular case, "the subject matter over which the fiduciary obligations extend",211 so that there may be identified the breach or apprehended breach for which the plaintiff seeks relief from a court of equity. The subject matter here is the provision of medical treatment after, or in the course of, consultation with the patient.

Secondly, the discussion of the principle by Deane J in Chan v Zacharia212 identifies the fundamental objection by equity to the pursuit by the fiduciary of personal interest in conflict with the interests of those whom the fiduciary is bound to protect. Likewise, the fiduciary is obliged not to enter upon conflicting engagements to several parties. This is

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because the fiduciary (for example, a solicitor acting for vendor and purchaser) may be unable to discharge adequately the one obligation without conflicting with the requirement for observance of the other obligation.213

As indicated earlier in these reasons, one answer to what otherwise would be breach of duty is the presence of informed consent.214 Further, a court of equity has inherent jurisdiction or power to authorise, at least in some cases, entry into transactions which otherwise would be in breach of duty.215

The fiduciary will be brought to account for any benefit or gain which (1) has been obtained or received in circumstances where a conflict or significant possibility of conflict existed between the fiduciary duty and personal interest in the pursuit or possible receipt of the benefit or gain or (2) was obtained or received by use or by reason of the fiduciary position or

opportunity or knowledge resulting from it.216 Where the breach of duty produces not a gain to the fiduciary but a loss to the party to whom the fiduciary duty was owed, then the judgments of Viscount Haldane LC in Nocton v Lord Ashburton217 and of Sir Owen Dixon in McKenzie v McDonald218 show that there is an obligation to account for the loss by provision of equitable compensation.

But none of this avails the appellant in the circumstances of the present case. The issue here is not that which would arise, for example, where a medical practitioner had advised the patient to undergo treatment at a particular private hospital in which the medical practitioner had an undisclosed financial interest, or where the medical practitioner prescribed one of a number of equally suitable pharmaceutical drugs for the undisclosed reason that this assisted the practitioner to obtain undisclosed side-benefits from the manufacturer.

In Moore v Regents of the University of California,219 an appeal was allowed against a decision to allow a demurrer to a cause of action pleaded for breach of fiduciary duty. The plaintiff alleged that his physician, who had treated him for leukaemia, had withdrawn from his body blood, bone marrow and other substances which, unknown to the plaintiff, were of use to the physician and his confederates in establishing a "cell line" in respect of which a patent was obtained. The physician then negotiated agreements for commercial development of the cell line and of products to be derived from it. The court, in deciding that a good cause of action was pleaded, pointed to the conflict between interest and duty involved where the research and commercial interests of the physician might tempt him to order a test or procedure which offered marginal or no benefits to the patient.220

In such cases, to adapt the language of La Forest J in Hodgkinson v Simms,221 the fiduciary principle would monitor the abuse of loyalty reposed in the medical practitioner by the patient. The abuse of duty would involve derivation of a benefit or gain by use or by reason of the fiduciary position or of an opportunity or knowledge which resulted from it.

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The present is not a case where, unless the respondent accedes to the right asserted against him by the appellant in this proceeding, the respondent will have derived a gain or benefit at the expense of the patient, beyond the agreed fee. Nor will Dr Williams have put himself in a position where his interests conflict with those of the patient. As was pointed out in the Court of Appeal in this case,222 to show that a medical practitioner owes fiduciary duties in certain circumstances to the patient is not to demonstrate a right in the patient to inspect and to take copies of the notes and records of the medical practitioner.

In this regard, care is required in translating into fiduciary law in general particular principles developed in the administration of trusts, particularly express trusts constituted by will or settlement. For example, in many such cases of what Lord Browne-Wilkinson has identified as the "traditional trust",223 the trustee will stand in a fiduciary relationship to a previously unknown (or unborn) beneficiary. Any element of subjective trust and confidence in the trustee will have been reposed by the testator or settlor, not by the beneficiary. Again, in some species of constructive trust, equity imposes the trust irregardless of any confidence reposed in the trustee.

Where an express trust has been effectively constituted and under its terms the trustee is obliged to manage a trust business, the trustee is required both to observe the terms of the trust and, in doing so, to exercise the same care as an ordinary, prudent person of business would exercise in the conduct of that business were it his or her own. There is a well accepted gloss on, or adjunct to, these requirements in relation to the exercise of powers of investment of a trust fund, pending distribution to those who are or who have become absolutely

entitled.224 The trustee is, of course, a fiduciary. But the above obligations arise from a particular characteristic, not of fiduciary obligations generally, but of the trust. This is the holding of the legal title to property with duties to deal with it for the benefit of charitable purposes or for one or more persons, at least one of whom is not the sole trustee.

Nor do these trustee obligations supply any proper foundations for the imposition upon fiduciaries in general of a quasi-tortious duty to act solely in the best interests of their principals. I agree with the observations of Gaudron and McHugh JJ upon what appears to be a contrary tendency in some of the Canadian decisions. I have expressed earlier in these reasons my view of the use in United States authorities of the phrase "informed consent".

Fiduciary obligations arise (albeit perhaps not exclusively) in various situations where it may be seen that one person is under an obligation to act in the interests of another. Equitable remedies are available where the fiduciary places interest in conflict with duty or derives an unauthorised profit from abuse of duty. It would be to stand established principle on its head to reason that because equity considers the defendant to be a fiduciary, therefore the defendant has a legal obligation to act in the interests of the plaintiff so that failure to fulfil that positive obligation represents a breach of fiduciary duty.

Conclusions

In McInerney v MacDonald,225 it was said in the Supreme Court of Canada that, if the patient is denied access to records held by the physician, it might not be possible for the

patient to establish that the medical practitioner had fulfilled the duty to act with utmost good faith and loyalty to the patient. It was then said:

If there has been improper conduct in the doctor's dealings with his or her patient, it ought to be revealed. The purpose of keeping the documents secret is to promote the proper functioning of the relationship, not to facilitate improper conduct.

Of that statement, several points may be made of present relevance. The first is that the appellant here seeks not the provision of the information contained in the documents (as to which there is an offer to provide a report which it is not suggested would be incomplete or inaccurate) but an extra-curial right to obtain, without prior invocation of the processes of the court, discovery and inspection. Secondly, the records now in question would be liable to discovery by compulsory process but the appellant has eschewed such a course. Thirdly, there is no suggestion made against the respondent of impropriety of any variety, including any alleged breach of fiduciary duty, as I have described that duty.

The engagement of the respondent was to advise and treat the appellant. The documents in question were brought into existence by the respondent or gathered by him for the purpose of providing that advice and treatment. The interests of the patient, in this case the former patient, are, one might think, protected by the general law, as it presently stands and in its various applications which I have sought to outline in these reasons.

The right asserted by the appellant does not exist nor are there any compelling grounds as to why it should be brought into existence. The immediate interests of the appellant stemming from the litigation in the United States may be met in the manner outlined earlier in these reasons. The principles of tort, contract and equity which I have outlined interact to protect the concerns of the appellant in receiving confidential advice and skilful treatment from the respondent, without abuse by him of the special position he occupies.

The appeal should be dismissed with costs.

Order

Appeal dismissed with costs.

Solicitors for the appellant: Cashman & Partners.

Solicitor for the respondent: E H Pike.

1 Some analogy may be found in a solicitor's entitlement to payment for providing copies of documents which, though related to the client's affairs, do not belong to the client: Re Thomson (1855) 20 Beav 545 ; 52 ER 714. In McInerney v MacDonald (1990) 66 DLR (4th) 736 at 744 (New Brunswick Court of Appeal), Re Thomson was cited to support a conclusion that a patient was entitled to access to a doctor's records. With respect, I do not think Re Thomson provides that support.

2 Hawkins v Clayton (1988) 164 CLR 539 at 573 ; 78 ALR 69 at 92 per Deane J

3 BP Refinery (Westernport) Pty Ltd v Shire of Hastings (1977) 180 CLR 266 at 283 ; 16 ALR 363 at 376–7 Secured Income Real Estate (Australia) Ltd v St Martin's Investments Pty Ltd (1979) 144 CLR 596 at 605–6 ; 26 ALR 567 Codelfa Construction Pty Ltd v State Rail Authority of NSW (1982) 149 CLR 337 at 346 ; 41 ALR 367 Heimann v Commonwealth (1938) 38 SR(NSW) 691 at 695

4 Leicestershire County Council v Michael Faraday and Partners Ltd [1941] 2 KB 205 at 216; Chantrey Martin (a firm) v Martin [1953] 2 QB 286

5 Copyright Act 1968 (Cth) ss 13, 31, 36; Commonwealth v John Fairfax & Sons Ltd (1980) 147 CLR 39 at 58 ; 32 ALR 485

6 [1967] 2 AC 46 at 127–8

7 (1984) 156 CLR 414 at 438; 56 ALR 193 at 208; see also Smith Kline & French Laboratories (Aust) Ltd v Secretary, Department of Community Services and Health (1990) 95 ALR 87 at 135–6 per Gummow J

8 See, for example, United Dominions Corp Ltd v Brian Pty Ltd (1985) 157 CLR 1 at 12-13 ; 60 ALR 741 at 747–9

9 Birtchnell v Equity Trustees, Executors and Agency Co Ltd (1929) 42 CLR 384 at 408–9

10 Johnson v Buttress (1936) 56 CLR 113 at 134–5

11 Birtchnell (1929) 42 CLR 384 at 409 per Dixon J

12 [1911] 1 Ch 723 at 728–9

13 Chan v Zacharia (1984) 154 CLR 178 at 195 ; 53 ALR 417

14 (1984) 156 CLR 41 at 102; 55 ALR 417 at 458; see also at CLR 73; ALR 435 per Gibbs CJ

15 (1984) 156 CLR 41 at 69; 55 ALR 417 at 432

16 Johnson v Buttress (1936) 56 CLR 113 at 134

17 (1992) 93 DLR (4th) 415 at 424

18 R v Mid-Glamorgan FHSA; Ex parte Martin, 2 June 1993 The Times, reported in Kennedy & Grubb, Medical Law: Text with Materials, 2nd ed (1994) at 619

19 The term appears to have its origin in the United States. See Canterbury v Spence (1972) 464 F 2d 772 at 789; Sidaway v Governors of Bethlem Royal Hospital [1985] AC 871 at 889

20 See Breen v Williams (1994) 35 NSWLR 522

21 Subsequently in the course of her appeals to the New South Wales Court of Appeal and to this court the appellant conceded that the respondent might also lawfully deny access to information created solely for his own benefit (eg fees and administrative records) and where the disclosure would found an action for breach of confidence by a third person

22 See Forster v Jododex Australia Pty Ltd (1972) 127 CLR 421

23 See Ainsworth v Criminal Justice Commission (1992) 175 CLR 564 at 581–2 ; 106 ALR 11

24 (1992) 175 CLR 479; 109 ALR 625

25 See Rogers v Whitaker (1992) 175 CLR 479 at 483 ; 109 ALR 625

26 See Leicestershire County Council v Michael Faraday and Partners Ltd [1941] 2 KB 205 at 216

27 [1953] 2 QB 286 at 293. See also Wentworth v De Montfort (1988) 15 NSWLR 348 where the authorities are discussed

28 [1920] AC 581 at 626

29 [1965] Ch 918 at 932–3 per Harman LJ, 935 per Danckwerts LJ and 937 per Salmon LJ

30 See Re Fairbairn (dec'd) [1967] VR 633 at 637–8; Re Simersall; Blackwell v Bray (1992) 35 FCR 584 at 588 ; 108 ALR 375; cf Hartigan Nominees Pty Ltd v Rydge (1992) 29 NSWLR 405 at 443

31 See FCT v United Aircraft Corp (1943) 68 CLR 525 at 534–5; Phipps v Boardman [1967] 2 AC 46 at 89–91, 102–3, 127–9; Brent v FCT (1971) 125 CLR 418 at 425; FCT v Sherritt Gordon Mines Ltd (1977) 137 CLR 612 at 630 ; 17 ALR 607 Moorgate Tobacco Co Ltd v Philip Morris Ltd (1982) 64 FLR 387 at 404; affd (1984) 156 CLR 414; 56 ALR 193

32 (1990) 22 FCR 73 at 121; 95 ALR 87; affd (1991) 28 FCR 291; 99 ALR 679

33 See BP Refinery (Westernport) Pty Ltd v Shire of Hastings (1977) 180 CLR 266 at 283–4 ; 16 ALR 363 Secured Income Real Estate (Australia) Ltd v St Martin's Investments Pty Ltd (1979) 144 CLR 596 at 605–6 ; 26 ALR 567 Codelfa Construction Pty Ltd v State Rail Authority of NSW (1982) 149 CLR 337 at 347, 404 ; 41 ALR 367

34 (1988) 164 CLR 539 at 573; 78 ALR 69 at 93

35 See the discussion by Deane J in Hawkins v Clayton (1988) 164 CLR 539 at 582–6 ; 78 ALR 69 at 100–3

36 See W v Egdell [1990] Ch 359 at 389

37 See Johnson v Buttress (1936) 56 CLR 113 at 134–5; Gibson v Russell (1843) 2 Y & CCC 104 ; 63 ER 46 Billage v Southee (1852) 9 Hare 534 ; 68 ER 623 Mitchell v Homfray (1881) 8 QBD 587

38 (1984) 156 CLR 414 at 437–8; 56 ALR 193 at 208–9

39 See Meagher, Gummow and Lehane, Equity: Doctrines and Remedies, 3rd ed (1992) Ch 15; Finn, “The Fiduciary Principle” in Youdan (ed), Equity, Fiduciaries and Trusts (1989) 1 at 17–18; Glover, Commercial Equity: Fiduciary Relationships (1995) Ch 8

40 (1984) 156 CLR 41 at 96–7; 55 ALR 417 at 454

41 See Tito v Waddell (No 2) [1977] Ch 106 at 229

42 See Chan v Zacharia (1984) 154 CLR 178 at 198–9 ; 53 ALR 417

43 See Finn, “The Fiduciary Principle” in Youdan (ed), Equity, Fiduciaries and Trusts (1989) 1 at 28

44 cf Moore v Regents of the University of California (1990) 793 P 2d 479

45 (1992) 175 CLR 479; 109 ALR 625

46 (1992) 175 CLR 479 at 483; 109 ALR 625 at 628. See also F v R (1983) 33 SASR 189

47 Sidaway v Governors of Bethlem Royal Hospital [1985] AC 871 at 893 per Lord Diplock

48 Gover v South Australia (1985) 39 SASR 543 at 551

49 (1992) 93 DLR (4th) 415

50 See Emmett v Eastern Dispensary and Casualty Hospital (1967) 396 F 2d 931 Cannell v Medical and Surgical Clinic (1974) 315 NE 2d 278

51 (1992) 93 DLR (4th) 415 at 424

52 McInerney v MacDonald (1992) 93 DLR (4th) 415 at 423

53 See Finn, “The Fiduciary Principle” in Youdan (ed), Equity, Fiduciaries and Trusts (1989) 1 at 28–9; Parkinson, “Fiduciary Law and Access to Medical Records: Breen v Williams“ (1995) 17 Sydney Law Review 433 at 442

54 McInerney v MacDonald (1992) 93 DLR (4th) 415 at 424

55 (1989) 12 EHRR 36

56 [1995] 1 WLR 110; [1995] 1 All ER 356

57 [1994] 5 Med LR 383. The Court of Appeal decision also appears in this report

58 [1994] 5 Med LR 383 at 392

59 [1985] AC 871 at 904

60 R v Mid Glamorgan Family Health Services Authority [1995] 1 WLR 110 at 117 ; [1995] 1 All ER 356 at 363

61 R v Mid Glamorgan Family Health Services Authority [1995] 1 WLR 110 at 117 ; [1995] 1 All ER 356 at 363

62 [1985] AC 871 at 884

63 [1914] AC 932

64 (1992) 175 CLR 479; 109 ALR 625

65 Bolam v Friern Hospital Management Committee [1957] 1 WLR 582 ; [1957] 2 All ER 118

66 Breen v Williams (1994) 35 NSWLR 522

67 Breen (1994) 35 NSWLR 522 at 542–5

68 Leicestershire County Council v Michael Faraday and Partners Ltd [1941] 2 KB 205 at 216, followed in Chantrey Martin (a firm) v Martin [1953] 2 QB 286 at 292–3; Wentworth v De Montfort (1988) 15 NSWLR 348 at 352

69 Halsbury's Laws of England, 4th ed, vol 35, para 1128

70 Sidaway v Governors of Bethlem Royal Hospital [1985] AC 871 at 904

71 Sidaway [1985] AC 871 at 903. See also Rogers v Whitaker (1992) 175 CLR 479 at 483 ; 109 ALR 625

72 Liverpool City Council v Irwin [1977] AC 239 at 254 cited in Hawkins v Clayton (1988) 164 CLR 539 at 571 ; 78 ALR 69

73 Hospital Products Ltd v United States Surgical Corp (1984) 156 CLR 41 at 139 ; 55 ALR 417 per Dawson J. See generally, Carter and Harland, Contract Law in Australia, 3rd ed (1996) at 205–9

74 Khoury v Government Insurance Office (NSW) (1984) 165 CLR 622 at 636 ; 54 ALR 639, citing The Moorcock (1889) 14 PD 64 at 68; BP Refinery (Westernport) Pty Ltd v Shire of Hastings (1977) 180 CLR 266 at 282–4 ; 16 ALR 363

75 See generally, Carter and Harland, Contract Law in Australia, 3rd ed (1996) at 210–12

76 Byrne v Australian Airlines Ltd (1995) 131 ALR 422 at 449 ; 69 ALJR 797 at 817

77 Byrne (1995) 131 ALR 422 at 450; 69 ALJR 797 at 817 citing Nullagine Investments Pty Ltd v Western Australian Club Inc (1993) 177 CLR 635 at 647–8, 659 ; 116 ALR 26

78 Glanville Williams, "Language and the Law — IV", (1945) 61 Law Quarterly Review 384 at 401. See also Carter and Harland, Contract Law in Australia, 3rd ed (1996) at 203, 210–11

79 [1985] AC 871 at 904

80 See Parker, Parkinson and Behrens, Australian Family Law in Context (1994) at 729

81 Rogers (1992) 175 CLR 479 at 483; 109 ALR 625

82 See Greaves v Baynham Meikle [1975] 1 WLR 1095 at 1100 ; 3 All ER 99 at 103–4

83 Carter and Harland, Contract Law in Australia, 3rd ed (1996) at 204

84 Hawkins (1988) 164 CLR 539 at 582–3; 78 ALR 69

85 Hawkins (1988) 164 CLR 539 at 584; 78 ALR 69

86 See, for example, Luxor (Eastbourne) Ltd v Cooper [1941] AC 108 Codelfa Construction Pty Ltd v State Rail Authority of NSW (1982) 149 CLR 337 ; 41 ALR 367

87 See, for example, Secretary, Department of Health and Community Services v JWB and SMB (1992) 175 CLR 218 at 270–4 ; 106 ALR 385 (Marion's case) per Brennan J

88 Sidaway [1985] AC 871 at 903

89 Sidaway [1985] AC 871 at 904

90 Sidaway [1985] AC 871 at 903

91 Jones, Medical Negligence (1991) at 16, fn 9

92 Sidaway [1985] AC 871 at 905

93 Hawkins (1988) 164 CLR 539 at 571; 78 ALR 69 citing BP Refinery (1977) 180 CLR 266 at 283; 16 ALR 363; The Moorcock (1889) 14 PD 64 at 68; Shirlaw v Southern Foundries (1926) Ltd [1939] 2 KB 206 at 227

94 [1995] 1 WLR 110; 1 All ER 356

95 Mid Glamorgan Family Health Services [1995] 1 WLR 110 at 116; 1 All ER 356 at 363

96 Mid Glamorgan Family Health Services [1995] 1 WLR 110 at 117; 1 All ER 356 at 363

97 [1985] AC 871 at 904

98 Mid Glamorgan Family Health Services [1995] 1 WLR 110 at 117; 1 All ER 356 at 363

99 Mid Glamorgan Family Health Services [1995] 1 WLR 110 at 117; 1 All ER 356 at 363

100 (1984) 156 CLR 41 at 69; 55 ALR 417 at 432

101 Hospital Products (1984) 156 CLR 41 at 96; 55 ALR 417

102 (1984) 156 CLR 41 at 97; 55 ALR 417

103 Hospital Products (1984) 156 CLR 41 at 96; 55 ALR 417

104 Hospital Products (1984) 156 CLR 41 at 69; 55 ALR 417 citing Tate v Williamson (1866) LR 2 Ch App 55 at 61; Coleman v Myers [1977] 2 NZLR 225 at 325

105 Hospital Products (1984) 156 CLR 41 at 69–70; 55 ALR 417

106 Reading v R [1949] 2 KB 232 at 236; Hospital Products (1984) 156 CLR 41 at 96–7; 55 ALR 417

107 Frame v Smith (1987) 42 DLR (4th) 81 cited in LAC Minerals Ltd v International Corona Resources Ltd (1989) 61 DLR (4th) 14 at 62–3

108 Johnson v Buttress (1936) 56 CLR 113 at 134–5

109 (1984) 156 CLR 41 at 98; 55 ALR 417

110 (1929) 42 CLR 384 at 409

111 Daly v Sydney Stock Exchange Ltd (1986) 160 CLR 371 at 377 ; 65 ALR 193

112 Matthew 6:24

113 [1896] AC 44 at 51–2 and see Chan v Zacharia (1984) 154 CLR 178 at 198–9 ; 53 ALR 417

114 [1977] Ch 106 at 230

115 Hospital Products (1984) 156 CLR 41 at 97; 55 ALR 417 at 454–5

116 Estate of Finkle (1977) 395 NYS 2d 343 at 344–5

117 Copyright Act 1968 (Cth) s 31(1)(a)(i)

118 (1992) 92 DLR (4th) 449 at 481

119 (1992) 93 DLR (4th) 415

120 McInerney (1992) 93 DLR (4th) 415 at 423

121 McInerney (1992) 93 DLR (4th) 415 at 424

122 McInerney (1992) 93 DLR (4th) 415 at 425

123 Rogers (1992) 175 CLR 479 at 483; 109 ALR 625

124 FCT v United Aircraft Corp (1943) 68 CLR 525 at 534–5

125 W v Egdell [1990] Ch 359 at 389, 415, 419

126 McInerney (1992) 93 DLR (4th) 415 at 424

127 The special circumstances of the case may, of course, create a fiduciary relationship which would require the journalist, accountant, bank officer or other person to reveal all relevant information to the person who gave the information. Commonwealth Bank v Smith (1991) 102 ALR 453 provides an example in the case of a bank officer. But none of these

persons owe a fiduciary duty to give access to records merely because they have received confidential information.

128 Parkinson, "Fiduciary Law and Access to Medical Records: Breen v Williams" (1995) 17 Sydney Law Review 433 at 439–40

129 Parkinson, "Fiduciary Law and Access to Medical Records: Breen v Williams " (1995) 17 Sydney Law Review 433 at 442–3; Finn, "The Fiduciary Principle" in Youdan (ed), Equity, Fiduciaries and Trusts (1989) 1 at 25–6

130 See J(LA) v J(H) (1993) 102 DLR (4th) 177; Parkinson, "Fiduciary Law and Access to Medical Records: Breen v Williams" (1995) 17 Sydney Law Review 433 at 441

131 See Finn, "The Fiduciary Principle" in Youdan (ed), Equity, Fiduciaries and Trusts (1989) 1 at 26

132 See Parkinson, "Fiduciary Law and Access to Medical Records: Breen v Williams" (1995) 17 Sydney Law Review 433 at 441–2

133 (1992) 175 CLR 479; 109 ALR 625

134 Rogers (1992) 175 CLR 479 at 490; 109 ALR 625

135 Tucker v US Department of Commerce (1992) 958 F 2d 1411 at 1413

136 Re Silicone Gel Breast Implants Products Liability Litigation (1992) 793 F Supp 1098. The significance of this litigation for the development in the United States of class actions in tort is discussed by Professor John C Coffee Jr, "Class Wars: The Dilemma of the Mass Tort Class Action" (1995) 95 Columbia Law Review 1343 at 1404–10

137 Breen v Williams (1994) 35 NSWLR 522

138 (1994) 35 NSWLR 522 at 550

139 Commentaries on Equity Jurisprudence as Administered in England and America, 8th ed (1861), vol 2, para 1495

140 Treatise on Discovery (1836) at 120

141 Chancery Pleadings, 5th ed (1847) at 221

142 Mitchell v Smith (1828) 1 Paige 287

143 (1838) 9 Sim 180 [59 ER 327]

144 (1889) 41 Ch D 151

145 Spence, The Equitable Jurisdiction of The Court of Chancery (1849), vol 2 at 11

146 (1838) 9 Sim 180 at 191; 59 ER 327 at 331

147 (1887) 11 NE 540

148 (1828) 1 Paige 287

149 (1887) 11 NE 540 at 548. Detailed statutory provision is now made in the United States. Title 28 of the United States Code states, in §1782:

"Assistance to foreign and international tribunals and to litigants before such tribunals

"(a) The district court of the district in which a person resides or is found may order him to give his testimony or statement or to produce a document or other thing for use in a proceeding in a foreign or international tribunal. The order may be made pursuant to a letter rogatory issued, or request made, by a foreign or international tribunal or upon the application

of any interested person and may direct that the testimony or statement be given, or the document or other thing be produced, before a person appointed by the court … To the extent that the order does not prescribe otherwise, the testimony or statement shall be taken, and the document or other thing produced, in accordance with the Federal Rules of Civil Procedure.

"A person may not be compelled to give his testimony or statement or to produce a document or other thing in violation of any legally applicable privilege."

150 [1974] AC 133

151 [1981] AC 1096

152 [1994] QB 366 at 374–5

153 [1980] 1 WLR 1274; [1980] 3 All ER 353

154 (1994) 35 NSWLR 522 at 527

155 See Coffee, "Class Wars: The Dilemma of the Mass Tort Class Action" (1995) 95 Columbia Law Review 1343 at 1409–10

156 (1994) 35 NSWLR 522 at 541–2; cf British Steel v Granada Television [1981] AC 1096 at 1168 per Lord Wilberforce

157 Sidaway v Governors of Bethlem Royal Hospital [1985] AC 871 at 904

158 (1988) 24 FCR 512 at 515–17; 90 ALR 595. See also Zador v Minister for Community Services and Health (1991) 24 ALD 165 R v Mid Glamorgan Family Health Services [1995] 1 WLR 110 at 113; [1995] 1 All ER 356 at 359. The Freedom of Information Act 1982 (Cth) ss 38, 40, 41, 43, 45, exempts certain documents from disclosure under that statute. See also Freedom of Information Act 1989 (NSW) s 31; Freedom of Information Act 1982 (Vic) ss 33, 35. The Privacy Act 1988 (Cth) (ss 89–94) creates a right of action for breach of obligations of confidence, with respect to "personal information", to which an "agency" or a Commonwealth officer is subject. Section 95 of the same statute provides for the issue of guidelines for the protection of privacy in the conduct of medical research.

159 Hawkins v Clayton (1988) 164 CLR 539 at 573 ; 78 ALR 69 Byrne v Australian Airlines Ltd (1995) 131 ALR 422 at 428, 443–7 69 ALJR 797 at 800–1, 812–15

160 (1986) 160 CLR 226 at 236–8; 64 ALR 481

161 Parry-Jones v Law Society [1969] 1 Ch 1 at 6–7, 9; Hunter v Mann [1974] QB 767 at 773, 775

162 Nullagine Investments Pty Ltd v Western Australian Club Inc (1993) 177 CLR 635 at 647–8, 659 ; 116 ALR 26 Byrne v Australian Airlines Ltd (1995) 131 ALR 422 at 447–52 ; 69 ALJR 797 at 815–19. See also Treitel, The Law of Contract, 9th ed (1995) at 190–4

163 (1992) 175 CLR 479; 109 ALR 625

164 (1992) 175 CLR 479 at 490, 492; 109 ALR 625

165 See, generally, as to the interrelation of, and distinctions between, the economic, ethical and social interests served by tort, contract and fiduciary law, Cooter and Freedman, "The Fiduciary Relationship: Its Economic Character and Legal Consequences" (1991) 66 New York University Law Review 1045 at 1053–6, 1064–74; De Mott, "Fiduciary Obligation Under Intellectual Siege: Contemporary Challenges to the Duty to be Loyal" (1992) 30 Osgoode Hall Law Journal 470 at 482–97. Further, in a given case, consideration also may be

required of statutory provisions requiring a particular norm of conduct, such as s 52 of the Trade Practices Act 1974 (Cth) and Pt VIII (ss 89–94) of the Privacy Act 1988 (Cth).

166 China & South Sea Bank Ltd v Tan Soon Gin [1990] 1 AC 536 at 543–4; Downsview Nominees Ltd v First City Corp Ltd [1993] AC 295 at 316; Spring v Guardian Assurance Plc [1995] 2 AC 296 at 334

167 Boardman v Phipps [1967] 2 AC 46 at 104, 105, 112, 117 NZ Netherlands Society "Oranje" Inc v Kuys [1973] 1 WLR 1126 at 1131–2; [1973] 2 All ER 1222 at 1227

168 The American authorities are collected in Mehlman, "Fiduciary Contracting: Limitations on Bargaining Between Patients and Health Care Providers" (1990) 51 University of Pittsburgh Law Review 365 at 388–414. See also Finn, "The Fiduciary Principle" in Youdan (ed), Equity, Fiduciaries and Trusts (1989), 1 at 24–6

169 (1992) 175 CLR 621; 110 ALR 1

170 (1994) 35 NSWLR 522 at 561

171 (1994) 35 NSWLR 522 at 538, 559–61

172 [1980] FSR 231 at 239–40

173 Estate of Finkle (1977) 395 NYS 2d 343 at 344–5

174 Gotkin v Miller (1974) 379 F Supp 859 at 864–8

175 Copyright Act 1968 (Cth) s 31(1)(a)(i)

176 (1970) 121 CLR 154 at 165–70

177 [1935] Ch 267

178 s 35(6)

179 See the definition of "artistic work" in s 10(1) of the Copyright Act 1968 (Cth)

180 s 43(1)

181 Avel Pty Ltd v Multicoin Amusements Pty Ltd (1990) 171 CLR 88 at 103–6, 119–20 ; 97 ALR 19 Lorenzo & Sons v Roland Corp (1992) 23 IPR 376 at 380–3; Devefi Pty Ltd v Mateffy Perl Nagy Pty Ltd (1993) 113 ALR 225 at 237–42

182 Gerald Dworkin, "Access to Medical Records — Discovery, Confidentiality and Privacy" (1979) 42 Modern Law Review 88 at 90

183 (1943) 68 CLR 525 at 534

184 Foster v Mountford & Rigby (1976) 14 ALR 71 Stephens v Avery [1988] Ch 449 X v Y [1988] 2 All ER 648

185 Moorgate Tobacco Co Ltd v Philip Morris Ltd (No 2) (1984) 156 CLR 414 at 437–8 ; 56 ALR 193 Johns v Australian Securities Commission (1993) 178 CLR 408 at 426–7, 455, 459–60 ; 116 ALR 567

186 (1980) 147 CLR 39; 32 ALR 485. See also O'Brien v Komesaroff (1982) 150 CLR 310 ; 41 ALR 255

187 W v Egdell [1990] Ch 359 at 389, 415, 419; Gurry, Breach of Confidence (1984) at 148–9

188 (1993) 178 CLR 408 at 460–3; 116 ALR 567

189 [1992] 2 SCR 138; (1992) 93 DLR (4th) 415

190 [1992] 2 SCR 138 at 159; (1992) 93 DLR (4th) 415 at 430–1

191 See the report of the intermediate appeal, McInerney v MacDonald (1990) 66 DLR (4th) 736 at 737, 740–1

192 [1992] 2 SCR 138 at 142; (1992) 93 DLR (4th) 415 at 418

193 [1992] 2 SCR 138 at 141; (1992) 93 DLR (4th) 415 at 417

194 [1992] 2 SCR 138 at 150–2; (1992) 93 DLR (4th) 415 at 424–5

195 [1995] 1 WLR 110; [1995] 1 All ER 356

196 [1995] 1 WLR 110 at 116; [1995] 1 All ER 356 at 363

197 [1995] 1 WLR 110 at 113; [1995] 1 All ER 356 at 359

198 [1995] 1 WLR 110 at 119–20; [1995] 1 All ER 356 at 366

199 Feenan, "Common Law Access to Medical Records", (1996) 59 Modern Law Review 101 at 102

200 1969 SC 72

201 1969 SC 72 at 82

202 cf Hospital Products Ltd v United States Surgical Corp (1984) 156 CLR 41 at 99–100 ; 55 ALR 417 Henderson v Merrett Syndicates Ltd [1995] 2 AC 145 at 206

203 Hospital Products Ltd v United States Surgical Corp (1984) 156 CLR 41 at 98; 55 ALR 417

204 (1936) 56 CLR 113

205 (1936) 56 CLR 113 at 134

206 (1936) 56 CLR 113 at 134–5

207 [1994] 3 SCR 377 at 406; (1994) 117 DLR (4th) 161 at 173–4

208 (1986) 160 CLR 371 at 377, 384–5; 65 ALR 193

209 Support for these formulations of the mainspring of fiduciary duty may be found in Hospital Products Ltd v United States Surgical Corp (1984) 156 CLR 41 at 72, 96–7, 142; 55 ALR 417; Mabo v Queensland (No 2) (1992) 175 CLR 1 at 200–1 ; 107 ALR 1 Glandon v Strata Consolidated (1993) 11 ACSR 543 at 549, 556–7; Hodgkinson v Simms [1994] 3 SCR 377 at 431–2, 465–8 ; (1994) 117 DLR (4th) 161 at 193, 217–19. In the last-mentioned case, there is disagreement between La Forest J on the one hand and Sopinka and McLachlin JJ on the other as to the degree of reliance which is requisite in respect of a fiduciary adviser, the former denying and the latter asserting the need for a wholesale or complete reliance. It is unnecessary for this appeal to consider the consequences of that division of opinion in Canada; see Ogilvie, "Fiduciary Obligations in Canada: from Concept to Principle" [1995] Journal of Business Law 638 at 643–4

210 De Mott, Fiduciary Obligation, Agency and Partnership (1991) at 20–2

211 Birtchnell v Equity Trustees, Executors and Agency Co Ltd (1929) 42 CLR 384 at 409 per Dixon J. See also the advice delivered by Lord Wilberforce in NZ Netherlands Society "Oranje" Inc v Kuys [1973] 1 WLR 1126 at 1129–30; [1973] 2 All ER 1222 at 1225–6, and that by Lord Mustill in Re Goldcorp Exchange Ltd [1995] 1 AC 74 at 98

212 (1984) 154 CLR 178 at 198–9; 53 ALR 417

213 Commonwealth Bank v Smith (1991) 42 FCR 390 at 391–3 ; 102 ALR 453 at 476–8 Haira v Burbery Mortgage Finance & Savings Ltd (in receivership) [1995] 3 NZLR 396 at 404–7

214 See also Glover, Commercial Equity — Fiduciary Relationships (1995), paras 5.123—5.132

215 Re Drexel Burnham Lambert UK Pension Plan [1995] 1 WLR 32

216 Chan v Zacharia (1984) 154 CLR 178 at 199 ; 53 ALR 417 per Deane J

217 [1914] AC 932 at 956

218 [1927] VLR 134 at 146–8. See also Mordecai v Mordecai (1988) 12 NSWLR 58 Hill v Rose [1990] VR 129 Wan v McDonald (1992) 33 FCR 491 ; 105 ALR 473 Bailey v Namol (1994) 125 ALR 228 Hodgkinson v Simms [1994] 3 SCR 377 ; (1994) 117 DLR (4th) 161 Target Holdings Ltd v Redferns (a firm) [1995] 1 AC 421

219 (1990) 793 P 2d 479

220 (1990) 793 P 2d 479 at 484

221 [1994] 3 SCR 377 at 406; (1994) 117 DLR (4th) 161 at 174

222 (1994) 35 NSWLR 522 at 570 per Meagher JA

223 Target Holdings Ltd v Redferns (a firm) [1996] 1 AC 421 at 434

224 In Australian Securities Commission v AS Nominees Ltd (1995) 133 ALR 1 at 12–13, the authorities in this area are discussed and the contrasting position of company directors is noted

225 [1992] 2 SCR 138 at 152; (1992) 93 DLR (4th) 415 at 425–6